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Contributors of Original Articles to Vol. XVII.

Allport, Frank, M. D., Chicago, Ill.

Barth, Geo. P., M. D., Milwaukee.
Brooks, E. H., M. D., Appleton.
Brown, H. M., M. D., Milwaukee.

Caffrey, A. J., M. D., Milwaukee.
Chapman, V. A., M. D., Milwaukee.
Commons, Prof. J. R., Madison.

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Dewey, Richard, A. M., M. D., Wauwatosa.
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Doege, Karl, M. D., F. A. C. S., Marshfield.
Donovan, Jeremiah, M. D., Milwaukee.
Dwight, C. G., M. D., F. A. C. S., Madison.

Evans, J. S., M. D., Madison.

Federspiel, M. N., B. Sc., D. D. S., M. D., Milwaukee.

Gaenslen, F. J., M. D., Milwaukee.
Gifford, H., M. D., Omaha, Neb.
Greeley, H. P., M. D., Madison.

Harper, C. A., M. D., Madison.
Higgins, S. G., M. D., Milwaukee.
Hogue, G. I., M. D., F. A. C. S., Milwaukee.
Hollender, A. R., M. D., Linden.

Jackson, J. A., Jr., M. D., Madison.
Jones, R. W., M. D., F. A. C. S., Wausau.

Layton, O. M., M. D., Fond du Lac.
Luten, Drew, M. D., Great Lakes, Ill.

Marshall, V. F., B. S., M. D., Appleton.
McFadden, J. F., M. D., Capt., U. S. A., Jefferson Barracks, Mo.
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Millstone, H. J., M. D., Chicago, Ill.

Ochsner, E. H., B. S., M. D., F. A. C. S., Chicago, Ill.

Palmer, Geo. Thomas, M. D., Springfield, Ill.
Pfister, Franz, M. D., Milwaukee.

Roberts, D. W., M. D., Milwaukee.
Rogers, A. W., M. D., Oconomowoc.

Seelman, J. J., M. D., Milwaukee.
Skemp, A. A., M. D., La Crosse.

Watson, Leigh F., M. D., Chicago, Ill.
Windesheim, G., M. D., Kenosha.

Zimmermann, C., M. D., F. A. C. S., Milwaukee.

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ORIGINAL ARTICLES

SOME PERSONAL CONCLUSIONS AS TO THE TREATMENT OF SENILE CATARACT.*

BY H. GIFFORD, M. D.,

OMAHA, NEBR.

Members of the Section: You need not fear that I shall attempt to cover the whole of this well-tilled field or that I shall regale you with tables of statistics. My excuse for selecting the subject is that in the course of 31 years of ophthalmic practice in Omaha I have reached some personal convictions on it, which I feel like emitting before it is too late.

The preparation for a successful cataract operation should begin with the operator. Leaving out of consideration questions of natural endowment and self control, I consider that it is worth while to begin special training of the hands as soon as a man decides that he is to follow ophthalmology as a profession. To become absolutely ambidextrous is a practical impossibility, but to improve the efficiency of the poorer hand is entirely possible; and this is important not merely at the beginning, or in the earlier years of one's career, but in order to postpone as long as possible the tendency to tremor which comes with advancing years. When I made up my mind to be an ophthalmogist I began systematically to use my left hand for a number of common operations, such as eating with fork and spoon and brushing teeth and have never had any difficulty in doing my corneal sections for the left eye with the left hand. I now wish, however, that I had also forced myself to do all my writing with the left hand because in the last few years while my right hand is as steady as ever, I have developed a fine tremor in the left, which, while not impairing its usefulness, makes it decidedly less ornamental; and I find that by practising writing with it from fifteen minutes to a half hour a day the tremor is perceptibly diminished.

PREPARATION OF PATIENT.

Out of the number of things that should be considered in the preparation of the patient, I shall touch on very few. If you would avoid unpleasant surprises, adhere strictly to the common rule of not operating without a test of the urine. In addition, I have of late made it a routine to have a careful examination of the nose, throat and teeth to reduce as far as possible the chance of focal infection; and all cataract patients are put upon liberal doses of yellow vaseline, to prevent intestinal stasis. As to what the real danger of focal infection is in cataract patients, I believe it actually to be very slight, and it is easy to be too much of a martinet for practical purposes. Some patients who are willing and anxious to have an operation on the eye, strenuously resist any interference with the teeth, no matter how useless or diseased the latter may be. In such cases, after explaining the possibilities of the situation, I make no bones about removing the cataract if the patient insists, against my advice, upon having this done without any interference with a mouth half full of rotten teeth.

With regard to the tear passages, if there is a stricture of the duct, I consider it inadvisable to attempt to restore the opening into the nose either by dilating the stricture or by removing the inner wall of the sac. A cure by probing is too slow, and making a large hole into the nose through the inner wall brings the eye into too intimate a relation with the germs of the nose. The sac should either be destroyed or excised; and in addition the canaliculi should be slit up and the pocket at the point where they unite should be cauterized thoroughly with the hot wire or trichloracetic acid. In the face of a plain case of chronic accessory sinusitis or other more or less incurable nasal disease, I believe it would be a good rule to destroy

*Read at the 71st Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 3-5, 1917.

the sac even where it and the duct are apparently normal. The only case of suppuration of the cornea which I have had in my last 500 cases was due, I believe, to a neglect of this precaution. Where the conjunctiva seems perfectly normal I do not make cultures, because even if pneumococci are found we have no safe and efficient means of ridding the sac of them; but as a matter of routine all patients are for 24 hours treated three times a day with chloride of zinc, a grain to the ounce, together with one per cent optochin, when the latter can be obtained.

INSTRUMENTS.

I have found a speculum something like this sample (Fig. 1) to be very useful. The stop-screw

Fig. 1

set on the outside of the two branches easily regulates their spread while the flat projections enable an assistant or nurse with practically no training to raise the lids away from the globe in the later steps of the operation.

For fixing the eye, I use a strong forceps with projecting teeth and fix by a firm grasp on the tendon of the internal rectus. This point of fixation permits perfect steadiness of the ball with comparatively little trauma; and in case of a deeply sunken eye (where it is often well to make an external canthotomy) the ball can be dragged forward so as to facilitate the incision.

Regarding the knife which the pupils of Indian Smith have introduced to this country, it is the most beautiful cutting instrument that I have ever handled, but I find that in using it, the aqueous escapes so early that the iris is often cut unless the counter-puncture and incision are hurried more than is desirable where one wishes to make a conjunctival flap. With a corneal incision this objection does not obtain.

For opening the capsule, I believe a capsulotome or toothed forceps to be best for most cases. The Kalt forceps without teeth will often dislocate or pull out the whole lens if the capsule is grasped below the center, a peculiarity welcomed by some but not by others. For many years I opened the capsule with the knife before making the counter-puncture. If this is done quickly with a dilated pupil and a rather narrow knife sharpened for a short distance on the back, it is on the whole the surest and safest method of opening the capsule, beside reducing the number of instruments to be introduced into the anterior chamber. I abandoned it as a routine measure simply because it leaves a narrow opening in the capsule with such thickened edges that discissions are more frequently necessary than where a broader opening is made. I still occasionally use the method for very tough capsules, which the knife opens better than any other instrument, and I always have a knife kept at hand so that if there is any doubt about the capsulotome having worked well, a peripheral cut in the capsule can be made if the lens fails to emerge readily.

For replacing angles of the iridectomy wound, in the face of threatened or actual loss of vitreous, in other words where it is of the utmost importance for the patient not to look down, I have found a reverse spatula like this (Fig. 2) to be of service.

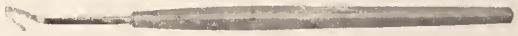

Fig. 2

The usefulness of this instrument is so obvious under these conditions that I am sure some of the advocates of intra-capsular operation must have used something of the kind but I happen not to have seen it mentioned.

Where it is necessary to pull out the lens, a single sharp hook or any one of the numerous loops or spoons generally works. But an occasional failure with these instruments led me, five years ago, to have made a slender loop with three small re-

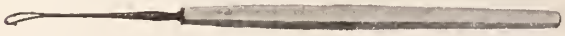

Fig. 3

curved hooks (Fig. 3) which slips in easily and always brings out the lens when it is withdrawn.

DRESSINGS.

Since 1887, I have been using a shield dressing for my cataract patients and others with large penetrating wounds. My article happened to be the first thing published on the subject of the shield dressing, although Lippincott and after him Fuchs had previously advocated verbally the same principle. The shield which I now use (Fig. 4) is similar to the popular Ring mask, over which it

has the advantage of being very cheap. It is made of brown pasteboard. The patient's name and the day of the operation are written on the outside, and when some use of either eye is permissible a hole is cut in one or both sides to permit, when the eyes can be left open, some use of the eyes with continued protection. It is fastened on with collodion and cotton or with adhesive straps.

ANAESTHESIA.

Perhaps the most important preliminary to a cataract expression is perfect anaesthesia, especially of the iris. This can generally be produced by

Fig. 4

using a drop of 10 per cent cocain five or six times during the half hour preceding the operation. But a surer plan, which has the advantage of facilitating the formation of a conjunctival flap, is to inject a couple of drops of 4 per cent cocain under the conjunctiva 3/16ths of an inch above the cornea and a single drop equally far back at points corresponding to two and ten o'clock respectively, then waiting for four minutes. It is not desirable to inject a larger amount of cocain than this because it makes the conjunctiva so oedematous that the incision cannot be made with accuracy and the conjunctival flap cannot be handled well, and does not apply properly at the end of the operation. When this is done the grasping and cutting of the iris generally causes no sensation whatever, and it is so easy for the patient to maintain the proper position of the eye that no fixation is necessary after the incision is completed.

CHOICE OF OPERATION.

I have the common opinion that a combined expression with the conjunctival flap certainly affords some protection against infection from the conjunctival sac, and while most of us probably have an exaggerated idea of the extent of this danger, it is certainly a comfort, where it seems necessary to leave some cortex in the chamber near the wound to have the latter well covered with conjunctiva. On the other hand where, after making the incision with a good sized conjunctival flap there is loss of vitreous, the flap is a nuisance and had better be cut away.

I do an iridectomy because when I tried the operation without an iridectomy in a series of about thirty cases, I had nearly 20 per cent of iris-prolapse, which effectually discouraged further experimentation in that line. Since then I have found the disadvantages of an iridectomy to be so entirely insignificant that I have not even been tempted to try the peripheral button-hole iridectomy. Judging from my own experience I believe that many operators have been led to try the simple operation (or a preliminary iridectomy) though the difficulties of operating with an insufficient anaesthesia of the iris; and that the disposition to try to get along without an iridectomy will disappear with the adoption of proper methods of anaesthesia.

As to a preliminary iridectomy, I was at one time so firmly convinced by the arguments of those who advocated this measure as one to be adopted in all cases when the patient had only one eye, that I carried the reasoning to its logical conclusion; namely, that if it is safer for patients with only one eye it should also be used for patients with two eyes; unless, after having our convictions explained to them they prefer the extra risk to the extra bother. Accordingly I did about fifty operations with a preliminary iridectomy but found that in practice, the method was open to decided objections. Unless the iridectomy incision is made practically in the cornea it is difficult or impossible to make a conjunctival flap at the final operation. Furthermore I found it difficult to resist the tendency to do the second operation before the congestion of the first had entirely disappeared.

Some cataracts also which were perfectly well suited to extraction at the time of the iridectomy, underwent such rapid disintegration after it that the final expression was much more difficult than it would have been at the time of the iridectomy. Finally, I lost one eye through a suppurative iritis which set in on the fifth day after a perfectly smooth iridectomy. Since then I have done the preliminary iridectomy only in rare cases where with a small central opacity in the lens, it seemed best to defer the expression and was yet worth while to give the patient the increased vision, in bright light, conferred by an iridectomy.

With the Indian intra-capsular operation I have had no experience. A careful consideration of the pros and cons leads me to believe that it is the best operation for ignorant coolies who come so far and go home so quickly that they have no chance for the proper care of secondary cataracts or even of an iritis; but that in view of the excellent visual results obtained with capsulotomy methods it has no place in civilized countries. The claims of its advocates that loss of vitreous is not any more common by this than by any other method should be interpreted with some qualification; since "loss of vitreous" to some of them apparently means something entirely different from what the ordinary operator means by this term. It seems to me the situation is well covered by an East Indian surgeon of large experience, whom I heard say that he did the intra-capsular operation on his coolies but not on his private patients. This may seem a rather harsh judgment on an operation which one has never tried but while I have never done the operation itself I have seen one case which leads me to think that the final chapter on its after-effects has yet to be written. The patient had been operated on by one of the most voluble advocates of the operation and had been sent home with vision of 20/20. A year later he came to me with the worst case of secondary cataract which I have ever seen. His vision with correction was 5/200 and his anterior vitreous had such a labyrinth of criss-crossing opacities that it seemed unlikely that he would ever regain useful vision with the eye. His local oculist, who had more optimism than I, succeeded by doing five discissions in raising the vision to approximately 20/40. I have since expressed the cataract of the other eye by the combined method with resulting vision of 20/15; and if it ever has a secondary cataract, I am sure it will not be as bad as the one which he had in the other eye.

With the intra-capsular method recommended by Stanculeanu and Arnold Knapp I have had some involuntary experience. On attempting to use the Kalt capsule forceps, I found, as they did, that when the capsule is seized below the center, the lens is very apt to be dislocated so that the whole cataract is removed as one would pick a berry from a bush; but instead of adopting this as a method, this experience has led me to discard the Kalt forceps except for immature cataracts, with which this result is not so apt to occur. The results in the six cases in which I have removed the cataract in this way have been excellent, with the exception of one case where the anterior vitreous showed a wrinkling which prevented vision better than 20/50; but my dread of vitreous prolapse is so great that I could not bear the thought of voluntarily enabling the patient to produce such a loss by suddenly looking down. So I have practically abandoned the use of the Kalt forceps for mature cataracts.

COMBINED EXPRESSION WITH SLIDING FLAP.

Although I commonly do the expression with an ordinary conjunctival flap, some experience which I have had with the sliding flap method advocated first by Kuhnt for especially dangerous cases; and with a slight modification by von Lint as a routine measure, has left some doubt in my mind as to whether the best interests of the greatest possible number of patients would not be served by making this the operation of choice. As you doubtless know, the special feature of the operation consists in dissecting loose the greater part of the upper half of the conjunctiva and putting in a suture at each side, which when tightened (after the operation is completed) draw the conjunctiva well down over the upper third of the cornea. The difference between the Kuhnt and von Lint method is that Kuhnt recommends another incision parallel to the first about 3/8 inch higher, to reduce the tension when the flap is drawn down. I removed a series of 135 uncomplicated cataracts by this method with good results in all except two cases. The main objection to it is that it takes from two to three times as long as the ordinary operation. Its great advantage consists in the comparative certainty that the wound or the contents of the cham-

ber, if not previously infected, will not be infected from the sac after the stitches have been tied; and more particularly in the aid which it affords in controlling loss of vitreous. Where for any reason it is evident, before the operation, that a loss of vitreous is to be feared, I believe the choice of the sliding flap should be mandatory; and in order that he may become familiar with the technique, I believe that every operator should remove a number of normal cataracts by this method. Where it is to be used for the express purpose of controlling loss of vitreous, I believe it is better to make the upper conjunctival incision parallel to the first as advised by Kuhnt, because if the vitreous escapes at all freely the flap, to be of much use, must be loose enough to come down very easily.

THE TREATMENT OF IMMATURE CATARACT.

If the intra-capsular operation ever comes into general use I believe it will be for the immature form of cataract; but even in this class of cases, its advantage over other methods still remains to be proved. A layman reading the articles of some of the intro-capsular men, would inevitably gain the impression that practically all other eye men were following the old practice of waiting for maturity; and I believe that the effect of the reprints with which the medical profession has been bombarded has been to convince most of the general practitioners that if any one of their number or of their patients happens to be afflicted with beginning cataract their only hope of speedy relief lies in the "Indian" operation. So it is up to those of us who believe the contrary, to take especial pains to convince the profession of the fact.

I think there can be no doubt that iritis is somewhat more apt to follow the expression of an immature cataract, where any considerable amount of cortex is left behind; but this risk is not so great that I would hesitate to have the operation on myself if I were the subject of slow-growing double cataract; and I should prefer to take such a risk with the capsulotomy method rather than the chance of loss of vitreous from an intra-capsular expression. This I believe is the position of the great majority of operators. The main question is: Shall we do some form of ripening operation? At present this question hinges chiefly on the value of the crucial discission of Homer Smith. The idea of ripening an immature cataract by opening the capsule is very old. About the first ophthalmic article which I ever read was one by Steffan, in Knapps Archives for 1883; in this he said that for immature cataracts he commonly performed a linear capsulotomy and removed the lens on the next day. This plan I have used at times since the beginning of my practice. The distinction of Homer Smith's method consists in the extent of his incisions in the capsule. With the single linear incision, the results are extremely variable. Sometimes very little result is produced unless the operation is repeated several times; while occasionally the lens will swell up so rapidly as to cause acute glaucoma. With the Homer Smith method, which I have used in ten cases, nearly all the patients developed glaucoma within 24 hours and one of them within three hours; but in spite of the adverse conditions under which the final operation had to be performed, all these patients eventually got good sight; and if I had followed Smith's rule to finish the operation on the same day that the capsulotomy is performed, doubtless much of the glaucoma would have been avoided. My main objection to the operation is that even where the anterior layers of the lens swell up and obliterate the anterior chamber, there is no certainty that the posterior layers have become opaque. In some cases I have found, under these conditions, that after expelling all the opaque lens matter there still remained a quantity of transparent cortex which caused as much delay in the after-treatment as one ever finds where an immature cataract has been removed without any ripening operation; so that for some years I have removed my immature cataracts without any ripening operation and have not yet lost an eye which I have treated in this way.

DANGERS ATTENDING THE NATURAL DEVELOPMENT OF CATARACT.

One of the commonest problems of the ophthalmologist is the decision as to what shall be done with the patient with a cataract in one eye and normal vision in the other. As nearly as I can judge, where the patient is not engaged in an occupation which demands the widest possible field, the common practice is to tell him to wait until the other eye shows signs of being affected and then return for an operation. I believe this practice is wrong, in that it overlooks two important dangers

to which an eye with senile cataract is subject. The first of these is glaucoma from the swelling of the cortex which occurs at the final stage of pre-maturity. In 1900 I reported a case in which, after following advice of this sort from me, the patient returned after a year or so with the lens much swollen and the eye entirely blind from the resulting glaucoma. Other cases of this sort have been reported by German writers and by Isaacs of Omaha. I have noted also that from the reports of Indian surgeons this sequence is not infrequently seen in that country. Much more frequent are the dangers which attend certain phases of hyper-maturity. A little hyper-maturity of a certain sort is not only not dangerous, but is a decided advantage, where a cataract has to be removed. I refer to the slow absorption of a moderate amount of cortex which produces a thin hard cataract with a deep chamber and which is sometimes taken for an immature cataract, because with oblique light the margin of the pupil casts a distinct shadow on the surface of the lens. Such cataracts need only a moderate sized incision, and come out very cleanly. This is the most favorable form of cataract for operation. Where, however, the cataract goes beyond this point, the capsule sometimes becomes so tough that the lens is dislocated in the attempt to open it, or it assumes the Morgagnian form so that when the capsule is opened a gush of milky liquid occurs and there remains a hard nucleus so small that it can be expressed with difficulty or it may have to be fished out. In these later stages the danger of loss of vitreous is somewhat greater than at an earlier stage; so that the impression voiced by Fuchs that, on the whole, the results of operations on hyper-mature cataracts are not so good as in earlier stages is commonly accepted. Aside from these well known dangers, however, these hyper-mature cataracts are subject to a form of glaucoma which seems to be very little known. I refer to the glaucoma which sometimes attends the beginning of a spontaneous cure of cataract. This connection has been noted by several writers, but the common opinion is that the absorption of the cataract is due to the glaucoma. My own conviction is that the reverse is the case and that the glaucoma, in these cases, is due to the effects of the disintegration of the cataract. I advanced this view first in 1900, basing it on my experience with four spontaneous cures of cataract; and at the Colorado Ophthalmological Congress in August of this year, I again defended this thesis as the result of having seen six other cases of the sort. In the discussion, Dr. Feingold of New Orleans said that he had seen cases which had led him to the same conclusion, and Dr. Schwenk of Philadelphia, also has recently reported to the Wills Hospital Association cases of glaucoma from what he calls hyper-reactive cataract; by which he evidently means the stage of beginning disintegration which ultimately leads to the spontaneous cure of cataract. In this form of glaucoma, the chamber is deep, the pupil small; and it is not infrequently attended with quite severe inflammatory symptoms due to the chemotactic effect of the absorbing cortex; so that the first impression given is sometimes that of an iritis or even of some metastatic infection. The eye sometimes undergoes a natural cure from this form of glaucoma but in half of the cases which I have seen total blindness has resulted.

As the result of these considerations, therefore, I advise patients with one good eye and a senile cataract in the other to report at regular intervals to some oculist to be sure that the cortex is not swelling too rapidly or that the process of hyper-maturity is not going too far; and where a perceptible shrinkage of the lens has occurred I inform the patient that if he wishes to give the cataract eye the best possible chance he had better have the cataract removed even if the other eye is perfectly good.

I will close these desultory and lengthy remarks by an admonition not to pass on the nature of any cataract nor to decide what should be done with it without inspecting it carefully with a fully dilated pupil. I mention this old and obvious precaution because up to a comparatively recent period I have sometimes neglected it to my own embarrassment and sometimes to the disadvantage of the patient.

DISCUSSION.

Dr. L. P. Allen, Oshkosh: Two years ago at the Clinical Congress in Boston I saw the same method used at the Massachusetts Charitable Eye and Ear Hospital that I saw in Knapp's in New York later. It turned out that the internes in those two institutions were interchanged at the latter end of the service of the seniors of the staff. I saw Arnold Knapp himself do several of these operations with the Kalt's toothless forceps. You may remember of at least two operations at the Soldiers' Home, Milwaukee, done by the Indian method. You may also remember the results in those patients. They were shown to us later. There was in both of those cases the wrinkled anterior portion of the vitreous.

When Dr. Fisher was here I asked him if the Arnold Knapp operation was the intracapsular operation, and he said no.

You may also remember when the operations at the Soldiers' Home were done there was a discussion as to whether the capsule was removed in those cases. I would like to ask Dr. Higgins what the results were in those cases. We know he did a discission in at least one of them. I think to those who were present at that time it would be interesting to know what the ultimate results were in those cases, as to discission. I believe there probably was no man in the world, we might say, who was any more the master of discissions than Herman Knapp. I was impressed at one time in New York with his results, and those of Boynton, over at the New York Ophthalmic College. Boynton always had reactions after his operations. It was very rare to see that happen in cases operated on by Herman Knapp.

Dr. Samuel G. Higgins, Milwaukee: First of all I think we ought to thank Dr. Gifford for giving us this very intimate and personal observation of his work, and of the college work of men whom he has seen who are masters of this subject. This means much more to us than the usual theoretical statements.

I would like to say, in answer to Dr. Allen and also to bring up a point which is important to me, which is not always touched on in such a discussion or paper as today, that I believe the younger eyes do best. My experience is founded mostly on old soldiers at the Soldiers' Home, and I find that men of about sixty with cataracts seem to get on wonderfully well; but these old boys of about eighty, you might just as well not operate, most of the time; and as they get along about seventy-five it is a more delicate operation. I remember operating on one man of ninety-three, and when I cut through the cornea it was just like cutting into a dead eye. And so it is in the older eyes: There is less vitality, and you do a method which has the minimum of trauma, or minimum of pressure. Above all, I think the intracapsular method is dangerous in these older eyes.

The men that Dr. Fisher operated out there: The first showed one man who had a clean pupil, and it was a successful intracapsular operation. It was unfortunate that he had choroiditis in the lateral area, so the vision was not greatly improved. The other man was an older man, and an unreliable patient, so it was necessary for Dr. Fisher to grasp the lens, and he extracted most of it. It was not complete intracapsular extraction. He had the posterior portion of the capsula remaining after the operation, and he had secondary cataract. The men I have seen, and the times I have done the intracapsular operation have been in men of about sixty, and when I had a good result it seemed to be so brilliant that the enthusiasm was quite pardonable that some surgeons have for the intracapsular method. Still it is rather a dangerous method, and I think about all should be done in the younger and healthier eyes.

I would like to say, while I am speaking about this point of experience which Dr. Gifford has given us, and which is much more than all our experience, probably, that the old men out there begin to clean up their eyes and get rid of any possible source of infection. It is better to wait a considerable period after you have begun to clean the tear sacs and extract the teeth. I would wait six months, or at least four months, in those cases before doing the extraction. If they have bad teeth they may even have a history of some pus in the lacrimal sac.

I do as little as possible by way of preliminary treatment. I always make a smear, and we use argyrol out there.

Dr. L. P. Allen, Oshkosh: I would like to ask Dr. Gifford if he would just discuss his observations, as a matter of relative judgment, as to doing the extraction of the cataract of the second eye after he got normal vision when the cataract is extracted from the first eye. That is, if the patient is happy, and has good vision, would you put him through the second operation?

Dr. Charles Zimmermann, Milwaukee: I know Dr. Gifford has developed a method of extraction, and I wish he would be kind enough to explain it.

Dr. D. V. Meiklejohn, Fond du Lac: Does Dr. Gifford use the specula to hold the eyelids open? Also whether he has gathered statistics as to the ultimate result where there is a slight loss of vitreous?

Dr. C. W. Wilkowske, Chippewa Falls: I have enjoyed the description in reference to the intracapsular operation—the Smith operation. I have tried it, and been successful in some seven cases, and they have been very happy results.

I think the important thing in the Smith operation is to get the incision large enough. I think most of us are afraid of getting the incision too large. You want to have the incision, for the Smith operation, involve more than half the circumference of the cornea, so it will not require much pressure to force the lens out of the eye. What led me to adopt that was an accident case. About eleven o'clock P. M. I was called to the suburbs of the city. The man was in a dirty saloon, and he had been in a scrap, and his antagonist had grabbed him with his thumb in the left eye, and cut his eye open with the thumb nail, and it was the most beautiful intracapsular operation you ever saw. The man was rushed to the hospital. I expected to have to remove the eye, but the next morning the anterior chamber re-filled, and the man suffered no discomfort and I allowed it to go on. We got a perfect result, and the vision was 20/20 with a + 10.00 lens.

The last case was a lady eighty-four years of age. The right eye was turned in when she was nine years of age, and was so far convergent that one could just see outer edge of the cornea. In the other eye she had senile cataract. About two months before this she suffered quite a severe injury to her head. At the time she came to the hospital she had entropion of both lower lids, with pus in the eyes. I did the entropion operation on both lower lids and two weeks later did the Smith operation on the eye. The patient left the hospital in

two weeks time and showed no reaction in the extracted eye. Eight weeks afterwards she came back and I found her vision was 20/20, and she was able to read D-1 at fourteen inches, with proper correction. That was an unusual result. In her case the pupil is absolutely clear. I had five cases where the patients were between seventy-four and eighty-five. Eighty-five was the oldest patient I operated on for cataract and I had 20/20 vision.

The important thing is to get the incision large enough. I use the Fisher lid hooks and those are very good if you have an able assistant. If your assistant forgets, and swings the hook a little too far backwards, you are liable to get pressure on the eyeball. I use the speculum Dr. Gifford showed, and after the incision is made lift up on the speculum and in that way avoid any pressure on the eyeball.

THE CHAIRMAN: Are there any other remarks? If not, we will hear from Dr. Gifford again.

DR. HAROLD GIFFORD, Omaha: With regard to the discission of secondary cataract, besides making the incision sub-conjunctivally, another important thing is that if you have a secondary cataract that is at all tough a much better instrument than the knife-needle is the baby cataract knife which you get by grinding down your old knives to about 1½ millimeters wide and about ¾ inch long. If you slide this under sub-conjunctivally and parallel with the iris and with a level motion after penetrating the membrane bring the blade down across the pupil, you open the capsule with a minimum of trauma. If you find that doesn't give you enough gaping, rotate the blade ninety degrees without withdrawing it and make a cross incision.

With regard to the question of operating on the second eye, if a person has a good result on the first one: I never urge a patient to have the second eye operated on where I have a good result on the first; but lots of patients think they have got such a fine result in one eye they don't see why they should not have it in two. There is no use arguing with them. I always tell them, if they are old people and have good vision in the one eye from the operation, there is no hurry about having eye from the operation, there is no hurry about having the other operated on—with this qualification which applies equally to the case where the patient has one perfectly good eye that has not been operated on and another that has cataract. If the patient is always going to have that good eye, then we can let the other eye go to pot; but how is he going to be sure? If we let the cataract go on to the stage of hypermaturity in which the chance of vitreous loss is increased, and the sight of the other eye is then lost from one cause or another, the second eye will have less chance of getting good sight than if it had been operated on sooner. It seems to me you have to put some of the responsibility upon the patient; explain to him what the situation is, that perhaps he will never have need for the second eye, but if to provide for all contingencies, he wants to give the second eye the very best chance, he ought to have the cataract removed before it gets too hypermature.

As to final results of loss of vitreous: I have not followed up these cases for years, but I know the immediate results of loss of vitreous are very unpleasant. I have had at least three expulsive hemorrhages. Of course we are taught to look for detachment of the retina after loss of vitreous. Unless the loss is very extreme I do not really expect that; in fact, I can not say that I have seen detachment of the retina that was occasioned by loss of vitreous; but we are much more apt to have extensive vitreous opacities, as well as long drawn out, and sometimes disastrous iritis.

Now, Dr. Wilkowske asked whether I manipulated the speculum myself, or have the assistant use it. The idea of these little projections on the speculum is to make it easier for the assistant to pinch the branches together and raise the lids away from the globe as soon as the lens has been expelled. In that way you remove every bit of pressure on the eye-ball. If you have a case of loss of vitreous you do not need to pull out the speculum and clap the eye shut. I remember that was the regular thing in the old days; they snatched out the speculum and closed up the eye; trying to get it out of sight as quickly as possible. When you see you are going to lose vitreous, or have lost vitreous, simply have the nurse pinch this up. If you let the lids close you don't know but the patient will squeeze out all the vitreous that is left. If there is any blood left, you can pick it off; you can snip off the conjunctival flap if you want to, and do a lot of things in making the toilet, after loss of vitreous, which you cannot do unless you have this or some other device to prevent pressure from the lids.

ADDRESS OF THE CHAIRMAN, EYE, EAR, NOSE AND THROAT SECTION.*

BY GUSTAVUS I. HOGUE, M. D., F. A. C. S.,

MAJOR, SURGEON, WISCONSIN CAVALRY,

TO THE EYE, EAR, NOSE AND THROAT SPECIALISTS OF THIS SECTION OF THE WISCONSIN STATE MEDICAL SOCIETY: I send my hearty greetings and sincerely hope that this meeting may prove a success beyond our fondest expectations. I am not unmindful of the honor of being chosen Chairman for this the first sectional meeting of the Wisconsin State Medical Society. I regret, however, that owing to military duties with the Wisconsin National Guard, it will be impossible for me to take an active part in the meeting. The success of the sectional meeting is uppermost in my mind and I know it cannot fail to bring about any but good results to the profession in this State.

As you probably know all members of the State

*Read at the 71st Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 3-5, 1917.

Medical Society, and that includes the County Medical Society, practicing the specialty of the Eye, Ear, Nose and Throat are automatically members of this section. As such it is earnestly hoped that every member will strive to bring this and future meetings up to the highest standards. These gatherings should engender the kindliest feelings among men engaged in the same field of labor and co-operation should be the key-note of this organization.

The program as arranged this year has as its aim the idea of interesting not only the specialist but also the general practitioner, and it is hoped that the latter will feel at home in our midst.

I would not be just without giving due credit to our present Secretary whose labors during the past two months have been to shoulder the completion of this program.

There is so much to do both in civil and military life these days, and in the latter there is a heavy demand on the eye, ear, nose and throat specialists of this State and country. It is earnestly hoped that each member of this society will not fail in doing his bit, be it at home or abroad. No member should wait to be drafted into military service, but gladly accept this opportunity to give his services to his country if he is so situated that he can serve, and he will reap that state of satisfaction that can only come to one that will forget self and of his own free will and accord serve, and if need be lay down his life for his country. I feel certain that the members of this society will see and do their duty.

The first American in the Expeditionary Forces of the United States to be killed in France was a Medical Officer. The War Department has announced that Lieutenant William D. Fitzsimmons, Medical Reserve Corps, a native of Kansas City, was killed, and that two privates of the Medical Department and one enlisted man of the Reserve Corps, with several other privates and nurses, were wounded. There were also, in the Harvard Base Hospital Unit nineteen patients that were wounded as a result of an aerial attack on September 4th, 1917. The Medical Department of the Army has suffered a great loss in the death of this officer, and the medical profession honor him in that he voluntarily offered his services and lost his life while on active duty caring for the sick and wounded soldiers.

The care of the blind as a result of this war is a problem which should receive due attention at this moment. I would like to hear that some action has been taken to establish a home for the care and education of the unfortunate men that will return to this State without the sense of sight. There is no more pathetic spectacle than the victims sent from the front blinded by shrapnel, bullet, or liquid fire. Let those that remain at home see to it that these unfortunate men are properly taken care of when they return.

It has been charged by no less a personage than the President-elect of the American Medical Association that a large number of surgical operations are performed unnecessarily every year. Dr. Bevan believes that this condition is due to three causes: ignorance, dishonesty, and bad judgment, and he recommends the Golden Rule to be practised by all surgeons. I believe we have arrived at the stage when we should follow the example of the present Army Medical Board which is composed of men prominent in Head Surgery. In such a combination we would include an Ophthalmic Surgeon, an Ear, Nose and Throat Surgeon, a Brain Surgeon, and an Oral Surgeon. Such a group of specialists with ample laboratory and Roentgen Ray apparatus will prove a God-send to the patient as well as to the surgical profession.

Members of this society should not fail to not only discourage but assist to convict any of our fraternity that stoops so low as to split fees.

The prevention of blindness must find its staunchest leaders in our specialty, and the eradication of blindness due to Ophthalmia Neanatorum will be accomplished in this State only when every member of our society will exert his efforts in the education not only of the midwives but, sad to relate, the medical men. I would consider that my life work was complete if a society for the prevention of blindness was established in every city in this State. It is up to you, the representatives of the cities from whence you came to inaugurate such a society. It is not a difficult task and you will find that the laity will respond eagerly to join you in this work. You may pattern your society after the Wisconsin State Association for the Blind whose headquarters are in Milwaukee.

Such nostrums as Bon-Opto should receive your strongest condemnation by mouth and pen. The state chemists of New Hampshire in their bulletin for 1917 state that Bon-Opto contains:

Sodium chloride (common salt)...39.52

Zinc sulphate (white vitriol) 6.83
Boric Acid 39.69
Menthol .....a small amount

The owners of this nostrum must agree with the late P. T. Barnum that the American public want to be humbugged for they do not hesitate to proclaim in print that a man, "almost blind," used Bon-Opto and now "can read everything"; a woman to whom "the trees across the street" were for several years but "a dim green blur," was able to "count the fluttering leaves" after using Bon-Opto!

I can not say when I will be with you again, but I hope it will be in the near future when peace on earth and good will toward men shall prevail.

ADVANTAGES AND DISADVANTAGES IN USE OF METALLIC BONE PLATES FOR FRACTURES.*

BY DR. KARL DOEGE, F. A. C. S.,

MARSHFIELD.

The repair of broken limbs forms probably one of the first and oldest endeavors of the surgeon. The result he attains either proclaims him a man of skill in the art of healing or one of mediocre ability, or worse. A perfectly healed and well functionating limb is certainly a credit to the attending surgeon. An imperfect result, even though it were the best attainable under the circumstances, is to him a constant reminder of his shortcomings and a source of great dissatisfaction to the patient.

The advent of the Roentgen Ray marks a distinct epoch in the history of the treatment of fractures. It simplifies the problems of diagnosis markedly and the X-Ray laboratories now solve them for us with ease and certainty.

However, while thus lessening our burdens and aiding us, the X-Ray at once has become a very exacting master and critic. Fractures that were thought to be reduced perfectly, under the scrutinizing eye of the X-Ray, were found to be far from what we expected. It revealed our errors and failures. It also emphasized the fact that frequently, in spite of repeated and painstaking efforts, perfect reduction of the fragment was not attainable by the means heretofore in vogue. In doing so, it has pointed the way toward better results and has spurred us on to set the goal of our endeavors far in advance of what it used to be.

It is probable, through the recognition of these facts, that the idea of the use of metallic splints in the treatment of fractures was born.

Under the term "Metallic Splints," I mean those metallic devices that, in the form of plates, are put alongside the broken ends of bones and which, by means of screws driven through the eyes of the plate and into the bone, hold the fragments in the position intended. In the broader sense of the term, it might include anything that holds the bone fragments in position, such as wire, nails or metallic bands. In this paper, however, we shall refer only to those metallic splints known as bone plates, as originally devised by Sir Arbuthcot Lane of London.

In order to discuss the advantages and disadvantages of the use of bone plates in the treatment of fractures, it seems to me desirable to obtain a comprehensive understanding of what are the essentials and guiding principles of such treatment. I would emphasize from the start that merely exact and firm union of the broken bones constitutes but one of the elements that enter into our consideration; that the restoration of injured soft parts, such as muscle and nerves and the maintenance of the health of those that escaped injuries, is just as essential. Any method of treatment that has for its object only the correct alignment of the fragments and of their proper retention until firm union has taken place, without due regard to the welfare of the soft tissues, must of necessity lead to disaster. As a flagrant example, I wish but to mention the unfortunate cases of ischaemic contractures due to too tight and prolonged bandaging.

When a fracture takes place, the fundamental lesion of course is in the bone and its proper adjustment is of paramount importance. We know that the anatomical form of every bone is determined by the function it has to assume. Its irregular angles or corners, its sulci, its ridges, its protuberances and its depressions serve a distinct object. Here it is a ridge that serves to give space for the origin of a muscle, there is a protuberance that permits of firm attachment of a tendon. Here is a groove that gives a resting place for a cord, there is a furrow for the safe lodgment of nerves and vessels. The very lines of the histological ar-

*Read at the 71st Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 3-5, 1917.

rangement in the structure of the bone is determined with a view of giving strength and firm support. The size and strength of the muscles depends upon the tasks they have to perform, the length of the tendons varies with the distance of the part whose motion they are to produce. Their action is regulated to a nicety and the firm and even balance between the traction of the extensors and flexors is truly ingenious. All this well planned arrangement, or much of it, is interfered with the moment a bone is broken. The bones are displaced, ends often splintered, vessels are ruptured and bleed into the tissues, muscles are torn, the tendons become slack and limp, all function ceases at once and the irritated and bruised nerves, through the sense of pain, give us warning not to move lest still more harm be done.

It is evident that the first step towards the return to the normal, the first essential of the treatment of simple fractures, is, to put the fractured ends into their former position. It is also evident that the greater the accuracy with which this is accomplished, the more certain will vessels, nerves, muscle and tendons return to their proper position, and the sooner will the nice balance of strength and tension of the muscles be re-established. It is furthermore evident that if the ends of the bones are not put into their former position and alignment, or we will say be but poorly approximated, perhaps partly overlapping or bent, that the action of the muscles, even after the union of the bone and repair of the muscles has taken place, cannot follow the same easy lines as formerly, cannot pull as directly and to their best advantage as they did before the distortion of the bone occurred. It is just to assume that the greater the misplacement or viscious union, the poorer the future function of the muscles, and the less the displacement, the better the return to the normal. I do not wish to convey the impression that a poor anatomical result of necessity implies a bad function. We know that owing to the great adaptability and automatic compensation of the tissue, useful functional results may be obtained in anatomically, poorly set fractures. However, this can only be accomplished after a prolonged period of disability, and never attains to the perfection of its former condition.

What has been said of the action of muscles applies doubly to the action of joints. In fractures near or into a joint, the fragments but rarely are returned to their former exact apposition and if the ankle joint is involved, or the small bones of the foot, the prolonged period of disability and the weakness and lasting pain is notorious. It is but fair to assume that if it were possible to place all fragments exactly into their former position, that practically undisturbed function would result. I would, therefore, place exact reposition of the fragments and their continued retention until healed, as the first essential in the treatment of fractures. As the second requirement, I would mention the proper care and treatment of the muscles that suffer so extensively from contusions and laceration at the time of the injury. We know that traumas to the soft parts, if they do not become infected, heal readily and completely. The swelling and blood extravasation soon disappears, especially if aided by early and gentle massage and moderate passive and active motion.

Just here, however, is where the difficulty arises. The various forms of splints and retention apparatuses must needs be applied with great nicety to allow sufficient space for swelling and expansion of the limb and at the same time, still be strong enough to hold the reduced fracture continuously in good position. Practically, this often is a most difficult thing to do. If the fracture is square and serrated, there will be but little tendency to redisplacement after reduction, but where the break is slanting and of a smooth bevel, very firm bandaging indeed is often done to prevent the bones from slipping after the fracture has been reduced with great difficulty and pain. Besides, the surgeon is often disinclined to disturb these retentive splints at as early a date as he would like, for purposes of inspection and massage, for fear of permitting the fragments to get out of place. As a result, the muscles and other tissues often suffer extensively through compression. The skin forms large blisters, the muscles are flattened, the tendons stiffened and more or less deep pressure sores over bony prominences result. Firm bandaging of the injured soft parts is hardly compatible with their proper repair and future good function, and often permanent and irreparable injury is done. In the severest cases, it takes the form of ischaemic contractures, which destroys the function of the muscles and make the limb absolutely useless, though the bone itself may be reduced ideally and its union be ever so firm.

I would, therefore, formulate as the two main

essentials of the proper treatment of fractures: First: Accurate reduction and alignment of the bones and the continued retention of this alignment. Second: Proper treatment of the soft parts by massage and passive and active motion.

The great aid that we receive by the use of the X-Ray in conforming to the first essential, that of exact reduction, has been alluded to, and its value cannot be overestimated. However, I will say that occasionally even this has failed to aid me to my complete satisfaction. X-Ray pictures and fluroscopic views are not always perfect, and it is no comfort to say that they should be. The fact remains that occasionally they are not as clear and illucidating as we would like to have them, especially when the bone is severely splintered.

It was therefore with a hopeful mind and a willing ear that we turned to listen to the teachings of Lane, advocating the open reduction and treatment of fractures by metallic retaining splints or bone plates. Though marred somewhat by the disastrous results obtained at an early period, by those not sufficiently equipped to carry on this work and by the unjudicious and indiscriminate use of the bone plate, the progress made by this method of treatment and the results obtained, have been very gratifying indeed. It may perhaps turn out in the future that the greatest benefit derived from the use of the bone plate is not so much the plate itself, but the open visual reduction of the fragments which it necessitates.

To enumerate the advantages of the open reduction of fractures is foreign to the title of this paper and I will only touch upon them by saying that it has done more to give us a clear understanding of fractures and of their proper treatment than anything else, not even excluding the X-Ray. It may therefore well be said that one of the advantages of the use of bone plates is the opportunity it gives the surgeon, to visually and accurately reduce the fracture.

How all important exact reduction is in the modern treatment of fractures, we only now are just beginning to appreciate. It eliminates subsequent pain, it shortens the period of disability markedly, it permits bony union by first retention, it avoids the formation of excessive callous, and puts the muscles and other soft tissues to the best advantage to resume their normal function early. Right here, we may state that we seriously "Question the absolute reduction claimed by those decrying the open method. One who has been confronted with the difficulties of reduction in open work, cannot help but question complete reduction by manipulation, when they are impinged between fractured ends, fragment of bone, muscle and soft tissue." Such absolute approximation of the fragments can only be attained by the open approach, and visually. While this method clearly comes up to a part of the above mentioned first essentials of treatment, i. e., absolute reduction, the remaining part of it, i. e., its continued retention, is especially well met by the application of the bone plates. No one can doubt the ability of the well fitted bone plate, securely held by proper sized screws, to hold the fragments in the position intended, and in that respect, it is a distinct advantage. It is after the bone has united and after further necessity for support by a splint becomes unnecessary, that the use and the advantages of the Lane plates have been seriously questioned. Its utility being passed, much depends upon its subsequent behaviour in the tissues whether by its persistence, it becomes merely inocuous or whether it develops into a distinct disadvantage. It may be considered proven, I believe, that the aseptic metallic splint implanted into aseptic tissues and not subjected to constant irritation, will remain there indefinitely, and without harm. It may also be considered accepted that an aseptic bone plate implanted into aseptic tissues, but exposed to repeated irritation, will be a source of more or less pain and a cause of disturbed function. That a plate imbedded under other than strictly aseptic conditions, either as a result of imperfect technique or otherwise, must necessarily lead to infection, discharging ednuses and to possible disaster, may also be taken for granted.

Admitting the correctness of these three axioms, we may well take them for our guide in deciding whether to use the Lane plate in a given fracture or not. Personally, I feel that the Lane plate is used to its best advantage in fracture of the diaphyses of long bones, of which the femur is the best example. In this fracture, the advantage of the Lane plate probably shows at its best. No matter whether the break is simple or comminuted, it can always be spanned over by a bone plate, or by several if need be. The loose fragments can be assembled and held in position by catgut placed through the attached periosteum or they may be gathered and held by a silver wire or metallic band

thrown around them. After the fragments are reduced and the plate firmly attached, it is covered deeply by the fibres of the quadruceps muscles. The foreign material becomes encapsulated and is worn without the least complaint on the part of the patient, and to his entire forgetfulness. Lane does not consider it necessary nor desirable to apply any further support in the shape of cast or splint than the bone plate, for safe retention. The slight amount of motion it does permit, serves as a stimulent to bony growth and promotes firm healing. But even if an external splint is applied, it should be easily removable so as to permit the early use of massage and passive motion, thus complying with the second essential of the principles we have formulated for the modern treatment of fractures, i. e., that of proper care of the soft parts.

May I say a few words as to the care of the soft tissues? The surgeon who has the best result in fractures, who has the earliest return of function, is he who watches his cases constantly, investigates and handles them a great deal. Why? Because in doing so, he removes the bandages frequently, feels and strokes and massages the flesh, limbers up the tendons, moves the proximate joints and prevents that atrophy of disuse that is bound to occur if the limb is left to itself for weeks at a time.

Bony approximation being assured by the Lane plate, or otherwise, the care and proper management of the soft tissues is the most important step in the case under consideration and one which is so frequently neglected. Through the use of the Lane plate, this part of the treatment can be carried out better than by any other method and this fact should be emphasized as an advantage of no mean importance.

The Lane method, from the first, intends that the plates should remain in the tissues permanently. When, in isolated cases, it became necessary, for various reasons, to remove them, it was invariably considered a slur on the judgment and skill of the operator and a point against the use of the plate. I must confess that I cannot bring myself to look upon it that way. For, unlike Lane and his followers, I have for a number of years advocated the removal of the bone plates as a matter of routine and whenever I have decided to use the plate. I have planned its insertion, not with a view of its permanent retention, but with an eye towards its subsequent easy removal. Under gas anaesthetic, this is done with very little inconvenience, and if the patient is previously advised of this step, we but rarely meet with opposition. This view, or modification of the method, has led me to use the bone plate rather light heartedly and with much fewer misgivings than formerly. It has materially relieved my surgical conscience, which revolts against the permanent implantation of plates and screws into the tissues. I know I shall remove them after their further usefulness has been brought to an end by the bony union of the fragments. This position, as to the application and early removal of bone plates, has rather widened their scope of indication with me and I am using them without fear near joints and in the neighborhood of tendons if I deem it necessary to procure accurate apposition and retention of the fragments. There is at present a prevailing tendency all over the country to decry and discard this valuable device. To me, the so-called "Passing of the bone plate" is not real. It will not be relegated to antiquity but, with proper discrimination, will remain a useful addition to our armamentarium.

Occasionally delayed or even non-union has been observed after the use of the bone plates and if it were caused by this device would form a serious disadvantage. However, I am persuaded that it is a possibility occurring in all open methods of treatment, as I have seen it reported following the use of the bone graft and we had one case where delayed union followed mere open reduction without inserting a support of any kind.

The slight disadvantage that the removal of the plate does constitute, is fully compensated and outweighed by the benefits derived because of accurate reduction, safe retention and ability to properly treat the soft tissues. The technique of application is definite and fairly simple, though inflexible as to asepsis, and easily rivals its competitor, the bone graft, the technique of which is far more complicated.

Perhaps I can best promulgate my opinion as to when, where and how to use Lane's plates, by stating the method as practiced at present at the Marshfield Clinic. Grouping them under various headings I may say:

1. All simple fractures that can be accurately reduced by manipulation, as demonstrated by the X-Ray, and that show no tendency to easy redisplacement, are treated by the closed method.

2. All simple fractures that are readily reduced by manipulation, but show a distinct tendency to

redisplacement, are treated by the open method of reduction.

3. All simple fractures that cannot be accurately reduced by manipulation, are properly adjusted by operation.

4. If, after correct open reduction, there is a distinct disposition on the part of the fragments to remain in apposition as determined by free passive motion of the limb performed while the wound is still open, no bone plate or other support is inserted and the wound is closed and merely external splints are applied.

5. Only those fractures that have been reduced by the open method, and which after reduction show a tendency to redisplacement, as determined again by free passive motion performed while the wound is still open, are immediately plated.

6. We advise the routine removal of the plate in all cases where there is a possibility of irritation, or where the plate may act as an irritant to joints, tendons or nerves.

Before bringing the subject to a close, it may be well to say a few words regarding the use of the bone plate in compound or infected fractures. To lay down a hard and fast rule would not be a wise undertaking as the degree of laceration, contusion and infection of the soft tissues may vary from a mere puncture to almost disintegration of the muscles. I think I have seen the bone plate applied with advantage in certain compound and infected fractures, but my personal leaning has been towards permitting the infection to disappear and the soft tissues to recover before applying a bone plate or reducing the fracture definitely.

I would distinctly warn against any operative work where the soft tissues are contused extensively, though the skin is not broken nor the deeper parts infected. They do not do well on operations of even the mildest type.

If I have succeeded in making myself clear, I hope the impression will prevail that I am not an ardent advocate of the multitudinous use of the Lane plate in all cases, but only in definitely selected instances.

It is to be regarded as a splint merely and its usefulness and desirability ends as soon as bony union of the fracture has occurred. The removal of the plate is always indicated but may be dispensed with in selected locations and at the wish o the patient.

In the light of what has been said, we may safely conclude that the proper use of the bone plate constitutes a distinct progress in the treatment of fractures and that it will ever be a useful instrument in our armamentarium.

DISCUSSION.

Dr. Wilson Cunningham, Platteville: Gentlemen of the Section: I personally do not feel like letting the statements stand favoring a promiscuous use of the Lane Plate. The Lane Plate requires removal in many cases, and there are other methods of retaining the parts. In the first place, with the Lane Plate the support is positive for but a very short time. The screws are loose within two, three or four weeks. Bone will not stand the pressure of steel or other metals for but a very short time. The Plate, if it serves its purpose at all, has to serve it within the first two or three weeks. It is a non-absorbable material, remains in the body tissues as a foreign body, and we do not know how unfavorable the result may be in time, following the remaining of such foreign material within the body tissues. It has also been shown by a number of men that the Lane Plate hinders bone formation in many cases. The bone formation will be faster on the side opposite the plate than it is on the side with the plate. If we are to use a plate I personally prefer and use, and I think it advisable to use one of an absorbable material. For the last three years I have been using either the bone graft or absorbable bone. One may make the plate and the pegs either from a soup bone or from autogenous bone. This will furnish the support the same as the Lane Plate. It does more than the Lane Plate. The Lane Plate becomes loose in a short time. With the use of the soup bone plate the plate becomes firm, and the circulation of the surrounding tissues extends into the plate and as the new bone formation extends, the plate is gradually absorbed. The periosteum forms underneath the plate where one uses the absorbable plate, and it also may extend over and around it and gradually it is absorbed. A plate made of bone does not hinder bone formation and it is absorbable and it does not require being removed at a subsequent time. It may also be used in an open wound or in a compound wound where it may not be advisable to use the Lane Plate.

Chairman: Is there any further discussion?

Dr. John R. Minahan, Green Bay: Mr. Chairman and Gentlemen: I have noticed with those that use Lane's splints it is necessary and it requires that they have the utmost skill, but there hasn't been anything said about the man that uses the old method or the closed method. If the Lane splints have produced the results they have under the most skilled operator it isn't a fair per cent to compare that with the dubs like myself who probably use the closed method. The great

trouble I think is that we don't use skill enough in reducing our fractures by the old method. Even after all the skill we can use there will be of course a small percentage of cases that will have to be treated, as Doctor Levings in his paper showed, by the open method; certain conditions that we can not overcome. But as we increase our skill of manipulation we will find that the men with the open method will get less and less cases, less and less. A man that gets a fracture—what is the first thing he does? He tries to pull it out. The first think in our day should be to get an X-ray of that fracture and he should study that X-ray and he should study the force that had been applied to put that bone out of place, and if he is going to get it back into place he has got to put it back in the direction of the force by which it was taken out. I have seen a great many very good men manipulate a fracture and it would surprise you—they will simply catch hold of the leg and pull it. Now, you know and I know and every one that has had anything to do with fractures knows that there isn't power enough to reduce a transverse fracture by a direct traction; it did not happen by direct traction, therefore you can't reduce it. If we will study that fracture or study that X-ray picture we can from the condition of the fracture and the displacement of it in a short time determine just the position that limb must have been in when that fracture took place. Then you have to bring that bone around into that position if you ever expect to reduce it, and reduce it properly. Now after we have reduced it are you going to be satisfied that you have it reduced? No. I think that years before we had the X-ray, before we had Lane's splints if we took an average of the fractures that were treated in those days that our average was a great deal better than today. I have had very many noted men tell me that they never had to take a Lane's splint out of the place. I know quite a few that they never took out but I had to take them out myself, and I never knew yet any one that had a Lane splint in the long bone, a long splint, that have a good limb without ever causing trouble in time. I think that probably in four or five years from now the Lane's splint will be a matter of medical history or surgical history, and with the number of cases that come to the surgeon and to the skilled surgeon you see it is not a fair comparison. They tell you, Doctor Levings tells you that only the most skilled will put on that Lane splint. If we have the same skill in reducing our fractures why the comparison in open operations would be very small.

For discovering sterility, whether it be of the man or the woman, take the urine of both of them in two separate vessels, and with it fermenting grains, and in that vessel in which there shall worms develop, whether it be hers or his, in that one there is sterility. Or take seven grains of barley, and seven beans, and seven of wheat, and put them into a pot, and then urinate within it, and if these grains shall sprout within seven days, then are you not steril, but if there be no sprouting then are you indeed unfruitful.—Albertus Magnus.

BONE GRAFTING IN THE TREATMENT OF FRACTURES.*

BY FRED. J. GAENSLEN, M. D.,

MILWAUKEE.

The subject of bone surgery has never held the interest of the general and special surgeon more intensely than at the present time, especially as it relates to the treatment of fractures. It is, therefore, entirely fitting that in this symposium on fractures the bone graft method receive due attention. In this discussion I feel that a careful consideration of the indications for the use of the bone graft in fractures is the all important point. Theoretical considerations concerning the fate of the bone graft and the histological changes involved while indeed interesting will be omitted, while details of operative technique will be dwelt on only briefly.

It is obviously impracticable to make any rigid classifications dividing fractures into those which should be treated conservatively and those which should be subjected to operation. Every case must be considered on its own merits and every surgeon must decide for himself which method in his hands and with the facilities at his disposal will give the patient the best results with the least risk. We may make an attempt, however, to outline roughly the general groups in which conservative methods will suffice and those in which the open method, and especially the bone graft method is justified or indeed indicated.

No exception can be taken to the statement that a perfect anatomical result makes for perfect function while defective reduction lays the foundation for serious impairment of function. But—while these general truths find ready acceptance we also note that in the vast majority of cases anatomical results, slightly and even considerably short of the ideal, will also lead to satisfactory functional results. Generally speaking accurate apposition, accurate alignment and perfect fixation are the three points especially to be kept in mind. To this might be added avoidance of needless interference when the above conditions are fulfilled. Accurate apposition of fragments, leaving no fracture surfaces uncovered by bone for the throwing out of large callus masses or providing opportunity for

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*Read at the 71st Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 3-5, 1917.

adhesion of soft parts is the first essential in striving for the ideal but given a slight over-riding if alignment and fixation are satisfactory no anxiety need be felt. Alignment and fixation are the most important, and, therefore, we are justified in many cases in allowing a result short of the ideal so far as apposition is concerned to pass uncorrected rather than take the added risks involved in any open operation.

The X-ray is not always an unmixed blessing. In many instances in which we can assure the patient of good function the X-ray reveals imperfections which are a source of great anxiety to the patient and from the legal standpoint to the surgeon as well. Saunders laments the growing tendency to rely too much upon the diagnosis made by the radiographer and an increasing tendency to operate in many cases in which conservative methods skillfully employed would suffice. He believes, with many others, that our precedessors who did not enjoy the advantages incident to the advent of the X-ray, were more skillful in making accurate diagnoses and more dextrous in their carrying out of the treatment. He urges, therefore, a more thorough study and consideration of the underlying anatomical conditions which will enable one to achieve excellent functional results by the usual conservative means in most cases.

In a general way, in fresh fractures of the long bones, operative interference should not be considered unless several attempts to secure and maintain accurate apposition have failed. In certain instances, of course, the anatomical condition of the fracture is such that it is evident from the start that conservative methods will prove futile. Robert Jones on the basis of a very large experience states that the only fracture of the long bones regularly presenting almost insuperable difficulties to satisfactory reduction is the spiral fracture of both bones of the leg, especially in the lower one-third. The difficulty he continues is not in reducing the fracture but in pursuading the fragments to remain in proper relation.

In those fractures, therefore, in which conservative methods have failed as well as in those in which such failure is a foregone conclusion operation is not only justified but definitely indicated. As in any surgical undertaking the general health of the patient must warrant the risk and proper hospital facilities including adequate armamentarium must be at hand. Hitzrod would add as an essential an adequate experience on the part of the surgeon. Unless these requirements be fulfilled, it is probably safe to say that even in these cases many patients would do better if treated along conservative lines than if subjected to any open operation.

In the treatment of fresh fractures of this type the surgeon has considerable latitude in the selection of the operative procedure. Among the various fixation methods the bone graft seems destined to occupy a prominent and permanent place and the sliding inlay graft, after the method of Albee, serves the purpose especially well. This method is so well known that the details of the technique are omitted. The essential point is that a graft cut from one fragment is slid across the fracture site engaging in a corresponding slot cut in the opposite fragment. Mechanically every indication is fulfilled. Exact apposition usually readily obtained with the fragments in clear view is maintained with greater security with the graft than with metal bands, plates or screws. It is well to emphasize also that this security is immediate which greatly facilitates the application of the plaster cast without endangering the accuracy of the reduction. It is not at all unlikely that during the bandaging of the limb and especially as a result of too vigorous rubbing in of the plaster the metal bands or plates are sometimes loosened at the very outset. Magnusen has carried out the same principles using thin sterilized bone plates and securing them with especially prepared bone screws. Two of these plates countersunk in slots in different planes in the long axis will hold any of these oblique fractures very securely. The bone plates are very thin and yet sufficiently strong to maintain accurate reduction. They are absorbed in time and replaced by living bone. It is claimed that they do not inhibit bone production as much as metal appliances. As a rule, no doubt, the inlay method just described will meet the requirements more fully, though in special instances the method of Magnusen may no doubt be employed to advantage.

The intramedullary graft in which a bone splinter or an especially prepared graft is thrust into the marrow cavity of either end will serve frequently in fresh fractures to maintain reduction but the conditions thus produced are far from ideal. While in the inlay method, above described, corresponding tissues, periosteum, compact bone,

endosteum and marrow are placed in apposition, this very desirable relationship does not obtain with the intramedullary graft. Practically this may mean less secure, at any rate, frequently delayed union. External fixation will be necessary for a longer period and restoration of normal function will not be as rapid as under more favorable conditions. Once an open operation is undertaken ideal results should be striven for and from this standpoint the intramedullary graft will not merit consideration very frequently.

The various metal bands are applied easily and quickly and apparently hold this type of fracture more securely than either wires or plates. While the reports so far at hand are excellent a longer period of time should elapse before the final verdict in the matter is rendered. In the more or less transverse fracture, as well as in the oblique, with jagged edges to engage with one another the metal bands may suffice but in many of the oblique without these irregularities the tendency to rotation and lateral displacement is so great that the best results are to be expected with the graft method rather than with the metal band.

In some instances with extensive comminution and displacement of fragments, involvement of nerve trunks, laceration of large vessels or interposition of soft parts operation will be indicated and in these one will have to be guided by the anatomical conditions present as to the method to be employed. In cases with extensive comminution in which operation is indicated it is entirely possible that a single plate would not be sufficient to hold the fragments in proper alignment. In such instances the graft would seem to offer the best solution in establishing firm continuity between the main fragments while the smaller pieces can be grouped about the connecting graft. In the cases in which involvment of a nerve trunk, laceration of large vessels or interposition of soft parts constitutes the reason for operative interference the metal plate or band will often suffice and the bone graft method while perhaps the more ideal does not offer sufficient advantages from the practical standpoint to counterbalance the added technical difficulties. Complications in the shape of operative infection or hematogenous infection many months after insertion of the metal plate are met with occasionally but it is a question whether the complications incidental to the bone graft operation if used more extensively would be less frequent.

While in the classes above mentioned there is room for difference of opinion as to the type of procedure to follow, whether bone plate, graft, screws or wires, etc., it would seem that in the treatment of ununited fractures there is really little room for argument. Metal appliances, after all, are foreign bodies. It is universally agreed that while as fixation devices they may be efficient they are nevertheless distinct hindrances to osteogenesis. In some instances there seems to be little doubt that the metal appliances have contributed to delayed union and even to non-union. Practically every radiograph of a plated fracture will show areas of rarefication, and osteoporosis about the screws. Were further evidence necessary on this point actual findings at secondary operations for removal of Lane plates would be convincing. The screws as a rule can be lifted out of the loose sockets without difficulty and the surrounding bone is soft and friable, indeed, not infrequently the screws are shown in the radiograph to lie loose in the soft tissue.

In cases of non-union, therefore, especially in the cases where there is marked eburnation with a consequent reduction in the osteogenetic power of the bone ends it should be our endeavor to aid rather than hinder this bone forming power. Albee's experience on this point certainly seems conclusive. He cites case after case in which union was secured by the bone graft after unsuccessful plating operation. The sliding bone graft or tibial transplant cut long enough to reach well beyond the area of eburnation, contacting with normal bone above and below and bridging the gap left after the removal of the sclerosed fracture ends solves the problem as nothing else will. Besides offering greater chances for union than any other method there is also little or no sacrifice of length of limb. After removal of a sufficient amount of the sclerosed ends and exposing normal bone it is but necessary to cut the graft of sufficient length to span the gap. The necessary thickness is made up by packing healthy bone bits about the graft and between the bone ends. The intramedullary graft should not be used in these cases for the obvious reasons that it is most difficult mechanically to insert such a graft sufficiently far into the fractured ends to secure contact with healthy bone at either end and when this is not done danger of non-union is imminent. It is perhaps needless to say that the most rigid asepsis is necessary while absolute immobilization is a prime requisite for the early

establishment of blood supply for the nourishment of the graft.

In malunion requiring correction, simple osteotomy and treatment as for simple fracture will often suffice. If some form of internal fixation is necessary the advantage would again lie with the graft rather than with the metal appliances for reasons just dwelt upon in considering ununited fractures.

A word in regard to infected compound fractures. Undoubtedly bolder attempts will be made in the future in the grafting of ununited infected compound fractures since the Dakin-Carrell method has given us more perfect control of wound healing. The reports of work along this line are indeed startling and the development in this field at the hands of military surgeons are most promising.

In conclusion it may be well to remember that the value of a surgical proceeding should be measured not by the results of a few men in whose hands the procedure has been developed but by the end results obtained by the majority of surgeons practicing the method. The conviction is spreading that were all the results of bone plating operations known the balance would incline strongly to the conservative side. The same conviction will probably be reached with reference to the bone graft in fractures when this becomes more widely used since the technical difficulties involved are greater. Unfavorable results are seldom published and complete records, if obtainable, would undoubtedly be a strong stimulant to using our best judgment so that the operation would be restricted to its proper and legitimate field.

DISCUSSION.

Dr. F. Gregory Connell, Oshkosh: Mr. Chairman and Gentlemen: A most important point brought out by the essayist is that there is no hard and fast rule allowing a classification of fractures into those in which operative or radical measures are indicated and another in which conservative or non-operative measures are to be employed. Each case is an individual problem and must be met by the circumstances and by the judgment of the surgeon in charge.

Because of the risk associated with the open method of treatment one may be justified in disregarding a moderate inaccuracy in apposition, if one has secured accurate alignment and perfect fixation of the fragments.

The essayist deprecates the placing of too much reliance upon the X-ray picture. The fault lies not with the X-ray picture but with an improper interpretation of the picture of the shadow of the bones. The X-ray should not be sufficient unto itself to arrive at a diagnosis, in fracture or anything else; it is merely one sign to be considered with other signs and symptoms, in arriving at a conclusion relative to the condition.

It will occasionally, if taken alone, lead even the more experienced into error; but if considered with correlated data is of the greatest value.

As a general proposition open operation of fresh fractures should not be performed until several attempts to secure a satisfactory adjustment of the fragments has failed. As the doctor said, the spiral fractures of the lower leg are notoriously different to deal with. The doctor failed to mention the matter of the more propitious time at which to operate upon fractures. It has been demonstrated that after an interval of about ten days that the results will be better than if the operation is performed before that time.

The technical side of bone grafting is most difficult; proper armamentarium and experience, are essential to success.

Regarding the use of metal plates, bands or bone grafts, our aim should be to bury as little foreign material as possible. An open operation will in some cases allow of a proper reduction of the fragments and their fixation without the use of any metal or bone graft, splint, or non-absorbable suture material; when this is possible it should always be done. When a splint is necessary it should, if possible, always be an autogenous graft. The inlay method is histologically and physiologically ideal, and is therefore preferable to the intramedullary graft, and the apparatus now available removed to a large extent the technical difficulties as an objection. In non-union the bone graft inlay method is the ideal and perhaps the only proper method of treatment. In such cases I would emphasize the necessity of long continued immobilization. The bone graft has found a secure and well established place in surgical methods, and will undoubtedly increase in popularity.

Dr. F. J. Gaenslen, Milwaukee: The X-ray findings of course are of inestimable value and should always be considered most carefully. The point I wish to emphasize is that we should study every case of fracture just as thoroughly as though we did not have the advantages of the X-ray and had to make our diagnosis on clinical findings. Having done this, the X-ray should be used as a confirmatory test. In many cases it is only by paying special attention to anatomical considerations that we can determine the reason for displacement of fragments and disturbance of alignment. Expert radiographers may often be necessary to help us interpret plates, but we should always have a clear picture in mind of what we are to expect and then study the radiograms carefully ourselves. If that is done, we are in better position to apply proper mechanical principles and devices in the reduction of the fracture. When I say that in many instances one should make several attempts at reduction I have in mind Hunkin's method of procedure. He uses three or four lead numbers or letters stuck to the skin with adhesive to mark the different levels and planes in the X-ray before and after reduction and by their means is able to determine accurately just what further steps are necessary to overcome over-riding

or deviation from the normal alignment. Once a fracture is set and apposition and alignment satisfactory all interference should be deferred until callus formation is sufficient to safeguard against redisplacement. Too early massage or functional use is responsible for much deformity and disability. Thomas of Chicago collected a large number of cases of plated fractures seen at Cook County Hospital. In this series the metal plates had to be removed in 48% of the cases. Such figures should serve to enlist our best judgment in every case so that we may recommend open operation only in those in which other measures seem doomed to failure.

THE X-RAY AS AN AID IN THE REDUCTION AND TREATMENT OF FRACTURES.*

BY JAMES A. JACKSON, JR., M. D.

MADISON.

The use of the Roentgen Rays in the diagnosis and treatment of fractures and injuries to joints is of the utmost value. At the present time they are to this branch of Surgery, as important as the Wassermann and Widal tests are to medicine. They not only show the line of fracture, but also the number and relative position of the fragments. One should not, however, rely entirely on this method to the exclusion of other means of diagnosis, but should consider it simply an aid, constantly bearing in mind the fact that wonderful results were obtained by careful painstaking men before the advent of the X-Ray.

Radiographs require careful study and not a mere glance and a snap diagnosis as is the tendency on the part of so many surgeons and amateur radiographers. Just as the surgeon should know his anatomy, so should the Roentgenologist familiarize himself with the plates of normal bones, joints, etc. This is especially true of complicated joints such as the Carpus and Tarsus, with the spine and bones of the skull. There is always the tendency, on the part of one who has not made a careful study of this subject, to call this or that line a fracture or to entirely overlook some other line, which in reality is a line of fracture. I believe the surgeon himself should study the plates and avail himself of every opportunity to improve his knowledge and familiarity with the X-Ray work and should never simply take the diagnosis of someone else who has done the work and who may perhaps have had no medical training whatsoever. By doing this, the surgeon will improve his knowledge of the pathology of fractures and will therefore be better able to put in practice the therapeutic principals underlying the treatment of them.

As a protection to his patient and to himself, both from a medical and a Medico-Legal standpoint, the surgeon must insist that an X-Ray examination, including plates, be made whenever possible. The courts of an Eastern State have held a physician guilty of malpractice who failed to have an X-Ray examination made of a case where the nearest apparatus was forty miles distant and moving the patient would have been no small difficulty.

X-RAY LABORATORIES AND APPARATUS.

Either have access to an up-to-date laboratory and make use of it, or have an apparatus of your own. In the cities, a hospital would be considered sadly deficient, were it not equipped with a good machine, and in practically every office building that has a half dozen physicians, there is one who makes a specialty of this work; with these facilities it is almost criminal for the surgeon to neglect the X-Ray examination of his fracture cases.

In the larger villages, it is a good plan for the men to have a co-operative outfit and have one of their number, or an outside man, devote most of his time to their work. In this way, physicians of the smaller towns will not only get excellent X-Ray service, but will get together and discuss their cases, improve their fracture work and promote a strong fellowship, an atmosphere which is so often lacking in many of these communities.

For the country practitioner who could not be expected to go to the expense of a large apparatus, there are many excellent, small machines which will do as good bone work as will most of the makes of a larger type.

METHOD OF EXAMINATION.

1—Plates.

2—Fluoroscope.

Whenever possible, especially in the smaller bones, it is well to make use of both methods. Always take plates even though you are perfectly satisfied with the fluoroscopic examination. The plates may not only show up some pathological

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*Read at the 71st Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 3-5. 1917.

condition, which was not revealed by the fluoroscope, but are a permanent record, may be studied at leisure, and if the case is taken into the courts, either in settlement of compensation or in a malpractice suit, may prove of the utmost value. Plates should be taken before reduction if possible, always afterwards!

TECHNIQUE—PLATES.

Technique 1.—Two views at right angles to each other I have found of more value than stereoscopic plates, however, where it is impossible to obtain the lateral view, as in the shoulder, hip and pelvis, stereoscopic plates are indispensible. I wish to emphasize this point, *never be satisfied with one view!* It may give you an absolutely erroneous idea of the pathology present.

Fluoroscope 2.—From the standpoint of economy—from the different angles from which you may view the case, before, during and after reduction the fluoroscope is a wonderful aid. If more use were made of it by ambitious surgeons during their reduction of fractures, better results would be obtained and there would be much less call for open operation with all its attending dangers. In my own experience I am just recovering from the stage when I wished to operate every fracture case that was unlucky enough to fall into my hands. We have in this city a most excellent colleague (Dr. Eugene Smith) who has been practicing and preaching for years the fact that many fractures, which most surgeons would operate, should, and can be reduced perfectly under the fluoroscope. I hope, if Dr. Smith is here, he will say a word or two on this subject.

ERRORS.

Most errors are made on account of poor or blurred negatives. Lengthening or shortening of shadows are made by not having the tube centered over the part at an exact right angle with the plate. Occasionally one fragment will overlap another and does not show the line of fracture. This fault may be obviated by taking the views at different angles. Magnification of the bones is due to the fact that the part rayed was not in close proximity to the plate. In this case a slight difference in not centering over the part makes a vast difference in the apparent separation or approximation of the fragments to each other.

I have made this part of my paper rather brief in order to show a few lantern slides of some of our cases which I will endeavor to explain as I go along.

DISCUSSION.

Dr. Eugene Smith, Milwaukee: There was something said in this paper about our technique for reducing fractures under the fluorescent screen. This technique is as follows: The patient is placed on the table and all bones which have been subjected to a force sufficient to cause fracture, are examined under the fluorescent screen. Fractures and dislocations having been found, the patient is anaesthetized and plates are first made showing the displacement of fragments. Then under the fluorescent screen the fragments are manipulated, pushing and pulling them into place, and splints are applied. Plates are now made to show reduction both for our own record and for the use of the lawyer who may be later interested in the case.

It does seem to me that in this symposium on fractures there has been very little said about the use of the fluorescent screen, and I believe personally, that as a matter of least deformity, least time lost in recovery, and for the greatest ensuing function, reduction under the fluorescent screen with anaesthesia, is a prime essential, and inasmuch as time is not an important factor and reduction can be made any time inside of a week, it is possible that every fracture be brought to the fluorescent screen in that time.

I wish to say, though it may be out of order, that when you think you have enough padding on your fracture, put on as much more. If you have plenty of padding and your muscles relaxed by flexion, you will have no trouble with your circulation in spite of rather tight bandaging.

The next essential after reduction is to put the parts absolutely at rest. Then comes the application of plaster paris, than which you will all agree there is nothing more important for immobilization, and this should be heavy enough and with sufficient reinforcing, and taking advantage of condyles and other prominent points to hold the muscles and bone fragments in place and at rest. The proper application of the plaster paris splints seems to be a rather neglected art. I believe if surgeons would pay more attention to it and would use the fluorescent screen in setting their fractures, that we would have fewer occasions for opening up fractures.

Chairman: I see that Dr. Albee is here, and I will ask him to say a few words.

Dr. Fred. H. Albee, New York: I did not expect to say anything at this time, Mr. President, because I will have lantern slides and moving pictures in my address in surgery this afternoon. But I am glad of the opportunity at this time to say a few words about fractures, because, on account of our war and our military work, it becomes a subject of greater importance than ever before. Of course, it has always been a most important subject, but at the present time we are facing a contingency which will involve the most difficult types of

fractures, and if my prognosis as to the duration of this war is correct, we may expect hundreds and thousands of these cases.

I spent all last summer in France and England and fortunately had a most exceptional opportunity of going all over France and studying the different fractures and the methods of controlling fractures and so on. I have been very much impressed by the papers presented, and the doctor certainly had very splendid lantern slides. I believe that a very important point, not sufficiently appreciated in the control of fractures, is the relationship between conservative and operative methods. I have been told many times that my opinion may be distorted because of the fact that in my practice I get the worst cases, bad fractures; quite a proportion of the cases I get are extremely bad and test the surgeon's skill and endeavors almost to the limit. The difficulties and criticisms which we meet have been largely due to the fact that our ideals have not been as high as they ought to be. I think Rohn has done a great deal in elevating our ideals, and I believe he has emphasized the fact that, from a mechanical standpoint, we should aim for higher ideals. I believe that is of great importance.

Now this is the way I believe that fractures ought to be treated: The surgeon gets his fracture into position, he has an X-ray and that X-ray shows that those fragments are not in good position. If he will just think in terms of mechanism and not in the terms of optomism he will be sure that that case will not be satisfactory. But he says here, I will take you into my confidence, here is the X-ray that shows those fragments, and I believe if you will let this go that you will get a good leg. Now: whether he expects Providence to do something to help him out I do not know, but it never happens; Providence doesn't interfere in these fractures; and when the man gets to walking around on that leg some months later—and it takes months—he finds that it is absolutely unsatisfactory. The surgeon might just as well have been frank and fair and stated that the leg was not right and must be rectified, and if he had given the surgeon a chance to rectify it, or did it himself if he is capable. I want to emphasize that word capable because these fractures are very difficult, and if he had done it himself or given the surgeon a chance, the first five weeks of that man's failure to have put those fragments in good position, the surgeon five months later hasn't an opportunity; the reparative process that takes place debars that surgeon from getting the ideal result. He can only operate the case, he can't get an ideal result. So my rule would be that you do not operate unless you have to; do everything that you can to avoid doing an open operation, but if you find by conservative means you have to do the operation, use every means that you have; if you find that you can't get those fragments in good position then decide within the first four or five weeks and operate the case and not wait.

Now, what the doctor said about screws: you know I have developed a technique that enables me to get along without foreign parts, without metal; I have only used one Lane's plate in four years time, and I get the most difficult cases. I have many men in and around New York, surgeons who do this: they follow my teaching about the matter and they try conservative means to the limit and when they have reached their limit then they call me in, and those cases of course are difficult ones always. We go in and certainly within the first four weeks put those fractures in position. We don't use the screws at all unless there is a mechanical defect, mechanical indication for it. You would be surprised how little force you really have to have to hold those fragments in position if you can just hold your ends on the bones so they won't override. In my observation of hospitals in many cities I find that they are not fully equipped. They will have all kinds of clamps and all kinds of mechanical arrangements, but if you ask them what they have got in the way of bone instruments such as a traction table, or a motor saw they say no. I had occasion a while ago right in the great city of New York where a man said he got up against it, got away from putting on a Lane's plate. It was overriding and necessitated position and he wanted me to come in and do it. I went into one of these big hospitals to do the operation. He had to assist me, and when we got to the operating room and prepared everything I said where is your traction table. We haven't got one. That very man some months ago, I had been talking with him, he said I don't understand how you are able to control these difficult fractures by the means you say you use. I took it for granted he had the equipment to work with, but it dawned upon me, remembering our past conversation, that he had been trying to work without implements to work with. Every man that is doing bone surgery should see to it that the hospitals furnish him the necessary tools. There is no kind of case that involves more responsibility than fracture. Hospitals get into trouble, and the surgeons also. Who is suffering the financial loss now? It is the insurance companies. If the profession does not wake up to this they are going to find that many are going to get in trouble because they will not stand for this kind of work. Hospitals must be equipped with the proper appliances.

Against all evil medicines, an amulet made of the gall-bladder of a black he-dog suffices; and it shall be worn upon the left arm, and it will also surely keep the house free from any harm, that hath its walls sprinkled of the blood of such a dog, if his genital member be buried under the threshold of the door of it. (Antri Magici.)

Would you remove the hairs from any part: then shall you apply the blood, or the bile, or the brain of a bat to that part; and also a viper boiled in oil is a most potent Psilothron, but first you shall remove those coarse hairs that be most stubborn. The blood and bile of a swallow hath great power to the same end. (Antri Magici.)

If you would make immediate cure of a carbuncle, lay upon it the dung of doves, or the seeds of hemp softened in vinegar, or bees dead in honey, or hyssop with scales of lead sodden in honey. (Zimara.)

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L. M. WARFIELD, M. D., Editor
79 Wisconsin Street, Milwaukee

J. P. McMAHON, M. D., Managing Editor
141 Wisconsin Street, Milwaukee

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EDITORIALS

TO WISCONSIN'S VOLUNTEERS.

THE organized profession of your state salute you with pride. You have made the big decision and have placed all personal considerations in the background for the period of the war. You have given your all for the noblest cause God has ever given man an opportunity to enlist in.

In relinquishing your work; in severing the ties that have bound you to home, friends, patients and loved ones; to enter a service that will lead you to we know not where; those left behind want you to feel that we are back of you, not only today, but tomorrow, and the next year and in the years to come. Yours shall not want. We pledge you this that you may better do the work that is yours to do, with the assurance that come what may, your medical fellows of Wisconsin have made them their own.

The Secretary of your state association asks that each of you convey to this office your wishes at any time. The organization is yours to use. Let us be of any help we can. And so to each of you as you are called we say Good Bye and God Bless You!

THE OWEN AND THE DYER BILLS.

NO discussion is needed in this Journal of the necessity for higher rank for our medical officers. Surgeon General Gorgas has appeared before the congressional committees and urged their passage. He has been opposed by Acting Secretary of War Crowell and line officers. The legislation asked by the Surgeon General is modest. If passed it will not give our medical personnel the rank held by medical officers in the allied forces. Are you doing your part in the support of these bills? Have you written your congressman? Here are the answers returned by Wisconsin Congressmen to a letter sent by the State Committee. Write your representative and Senator today!

Sen. Lenroot .....Evasive.
Sen. La Follette.....Evasive.
W. H. Stafford.....Evasive.
H. A. Cooper.....Will support.
J. J. Esch.....Will support.
J. M. Nelson.....Evasive.
W. J. Cary.....Will support.
E. Voight .....Evasive.
E. E. Browne.....Will support.
J. A. Frear.....Evasive.
J. H. Davidson.....Evasive.

FOR THOSE WHO REMAIN AT HOME.

THERE are many physicians who have tried to join the Medical Reserve Corps of the Army but were denied this privilege because they had passed the age limit of 55 years or presented some physical disability that unfitted them for the strenuous work of the army surgeon. Those physicians were keenly disappointed, for in them the spirit was strong to serve their country. For all such members of the profession an opportunity will soon be presented to render loyal service to the

country when the plan now being formulated by the National Council of Defense and the Medical Section of the Advisory Commission has been completed. This plan contemplates the formation of a Volunteer Medical Service Corps composed of physicians who were not eligible for the Medical Reserve Corps to form an organization that will meet such civic and military needs as are not already provided for. The rules for the formation of this corps and application forms for membership will soon be distributed and will fully explain the object and aim of the corps whereby physicians may render voluntary service to the country whenever and wherever practicable. The corps will respond to requests for service issued by the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service or any other duly authorized department or association. A state governing board of five members of the medical section of the state committee will have charge of the organization of the corps in the state and pass on all applications for membership. A designated mark has been authorized so that members of this corps can be recognized as having offered their services to our country in this time of need.

THE JOURNAL.

THIS Journal is yours. You make it. If it is to be better, you must make it better. The scientific articles are yours. They cannot be better than you write. The news is news of your activities. The editorials are comments on your interests. Every one is concerned in a better journal. Let us all help by writing better papers, by reading our ads, patronizing our advertisers, by keeping up better local societies, by being better secretaries, more active health officers, and the most conscientious doctors and patriotic citizens of which we are capable.

ASSISTING FAMILIES OF DOCTORS IN SERVICE.

VARIOUS plans from time to time have been suggested to aid the families of our Patriotic Physicians. Many county societies have adopted rules to pay to absent army medical officers a per cent of collections received from practice for their patients during their absence.

The following resolution was recently adopted by the Texas State Society through its House of Delegates:

Whereas, Every able-bodied doctor who can make the sacrifice is needed in the army, and

Whereas, The army pay is not sufficient to meet the expenses of many good men who would accept commissions except for this fact, and

Whereas, It is desirable that some plan be devised by which the patrons of the doctors who are in the service may be able to keep up their interests in their regular physicians and at the same time make it possible for the families of these physicians to live in comfort, be it

Resolved, That all county medical societies provide printed forms on which the patients of the doctors on active duty in the army may be able to request that one-half of the money paid by them for medical services shall be given to the dependent families of the absent doctors; be it

Resolved, further, That due publicity be given to these resolutions by newspapers, medical journals, etc. The following form is suggested:

"To Dr.....
.....
(Address)

"I hand you herewith $..... in payment for services as follows:
.....

"It is my desire that one-half of this amount be paid to..... dependent member of the family of Dr..... ..... my regular physician, who is at present on active duty in the United States Army."

Think it over.

INCREASE IN DUES.

ACCORDING to the Texas State Journal of Medicine, the following resolution was adopted at the Dallas meeting, May 10, 1917:

"An assessment of five dollars per capita on the membership of component county societies is hereby made the annual dues of the association. Of this amount not more than two dollars shall be the subscription fee to the Texas State Journal of Medicine, and one dollar shall go to the medical defense fund."

It appears that before the reorganization fifteen years ago, the State Society dues were $5.00 and

were then reduced to $2.00 with the effect of running behind during the last three years.

Nearly all the state medical societies have found it necessary to increase the dues, owing to the greater activities of these bodies in the last few years. The maintaining of high class medical journals and helping members in defending unjust malpractice suits, has added much to the expense of the societies, and with these must be considered the activities of the councilors in forwarding and maintaining organization, expenses of committees, etc. It has come to be recognized that the one way to represent and maintain the interests of the profession and to bring about legislation in the interest of public health and to render many of our public institutions more efficient, is to coordinate the activities of the profession of the state through the State Medical Society. In the past the American idea has been individualistic and the accomplishments have been slow and uncertain. During the past year or two we have been measuring ourselves by unusual standards and have found many points of weakness. We are being happily surprised at the facility with which we have remedied what we supposed were constitutional defects that made us different from other people. We have often been confronted with the argument that certain things might do in other countries but we were so different, our form of government forbade it. We are now seeing that much of this was nonsense. It may be granted that humanity and human ways may differ somewhat but among people of higher civilization there must be a similarity that even brings us into the family of nations, and we must do our part even if the way is strange and partly unknown to us.

MEDICAL MOBILIZATION AND THE WAR

CLASSIFICATION OF PHYSICIANS

THE MILWAUKEE MEETING.

Major Henry D. Jump of the Council of National Defense during the past month has spoken to medical and lay audiences at La Crosse, Madison, Beloit and Milwaukee. The Milwaukee meeting was held in the Museum Auditorium. A large and enthusiastic audience was present and Governor Philipp presided. Major Jump told of the needs of the medical department of the army and urged all who can possibly arrange their affairs at this time to make application to the Medical Reserve Corps at once. Reserve forces not in service have gradually dwindled each month since the beginning of the new year until the number now available is alarmingly small. He insists it is the duty of every ablebodied man under fifty-five to arrange his affairs and offer his services NOW, unless excused by his state committee through their belief that he is eligible for the Volunteer Medical Service Corps. Qualified men should have membership in one of these two organizations.

On Tuesday morning, May 28th, the Councilors of the State Medical Society and representatives of the Auxiliary County Committees of Medical Defense met in the Gold Room of the Hotel Wisconsin. Reports were presented and group round-table conferences were held, a table being provided for each councilor district. Maps and tabulated data showing number and percentage of enlistments for each county, number of square miles and population per physician, etc., were provided each table. A survey of medical resources of each county was then made. The questionnaires recently returned were available to determine the availability of each man. The physicians of the state were then classified according to the table which follows. In determining the class of each man, his age, education, family responsibilities, physical condition and the needs of his community were considered. Cases which could not be determined were referred to county committees for investigation.

It is felt that such a classification will be of benefit in that only those who should go now will be solicited to enlist. This will spare the man who is vitally needed by his community or family or institution until such time as the needs of the service demand men in his class. It will thus protect him, his family and the interests of the state as long as possible. On the other hand the man who should go because he is young, in good health, has a small family and can be spared without working a serious hardship on the community he serves, will be urged to go now, and if he fails to meet his obligation as a good citizen and a minister to

the sick, he will be told his duty in no uncertain language. The profession of the state should welcome this classification. Everyone to date has been solicited without regard to his condition or his responsibilities and it has been hard to decide. It is not easy to wrestle with your conscience when you are not sure. Every day men have written, "I am ready to go when men of my age and responsibilities are needed but how shall I know." You may now relax in the assurance that you will be called when your time has come and not before. The classification follows.

CLASSIFICATION.

I. a—Men in service, M. R. C.
b—Men in service—contract, Red Cross, Navy, National Guard or Foreign.
c—Have accepted commission—awaits call.

II. a—Has commission—not accepted.
b—Applied and examined—await commission.
c—Applied—not examined.
d—Will apply on fixed date.
e—Will join if replaced.
f—Will take contract.

III. a—Should go now—single.
b—Should go now—married.

IV. a—Could be spared.
b—Could be spared if replaced.

V. a—Important family obligations—needed where he is.
b—Important family obligations — not needed where he is.
c—Important family obligations—willing to replace other.

VI. a—Important teaching position.
b—Important public health position.
c—Important industrial position.
d—Important institutional position.

VII. a—Substituting for man in service.
b—Willing to substitute—disqualified.
c—Willing to substitute—not disqualified.

VIII. a—Discharged from service.
b—Refused commission on physical grounds.
c—Claims physical disability.
d—Known physical disability.
e—Over age.
f—Morally or mentally unfit for service.
g—Alien.

IX. a—Unclassified.

STATEMENT OF COMMISSIONS ACCEPTED.

May 28, 1918.

Order	County	Number	Per Cent
1.	Florence	1	100
2.	Washburn	5	55
3.	Burnett	2	50
4.	Forest	5	45
5.	Oneida	5	36
6.	Price	3	33
7.	Lincoln	6	33
8.	Jackson	4	31
9.	Racine	17	31
10.	Washington	8	31
11.	Buffalo	3	30
12.	Monroe	7	29
13.	Portage	9	27
14.	Bayfield	3	27
15.	Winnebago	16	26
16.	Manitowoc	11	25
17.	Marquette	3	25
18.	La Crosse	11	25
19.	Polk	2	25
20.	Barron	6	25
21.	Clark	6	24
22.	Langlade	4	24
23.	Ashland	5	23
24.	Marathon	10	23
25.	Oconto	4	23
26.	Brown	13	23
27.	Grant	12	23
28.	Trempealeau	6	23
29.	Waukesha	15	22
30.	Eau Claire	8	22
31.	Taylor	2	22
32.	Calumet	4	22
33.	Jefferson	8	21
34.	Shawano	5	21
35.	Douglas	9	20
36.	Sawyer	1	20
37.	Richland	6	20
38.	Chippewa	5	18
39.	Juneau	3	18
40.	Sheboygan	11	18
41.	Green Lake	3	17
42.	Fond du Lac	12	17
43.	Rock	15	17
44.	Ozaukee	2	17
45.	Milwaukee	108	17
46.	Green	4	16
47.	Outagamie	7	16
48.	Pierce	3	16
49.	Dane	26	16
50.	Dodge	7	15
51.	Walworth	6	15
52.	Iron	1	14
53.	Rusk	2	14
54.	Dunn	3	14
55.	Vernon	3	12
56.	Crawford	2	12
57.	Sauk	5	12
58.	Waushara	4	12
59.	Waupaca	4	11
60.	Kenosha	4	9
61.	Marinette	2	9
62.	La Fayette	2	8
63.	Door	1	7
64.	Wood	2	7
65.	Columbia	3	7
66.	St. Croix	1	5
67.	Iowa	1	5
68.	Vilas	0	0
69.	Kewaunee	0	0
70.	Pepin	0	0
71.	Adams	0	0
		494	Average 18%

INFORMATION AS TO SERVICE

The Surgeon General of the Army and the Surgeon General of the Navy need more medical officers. Our profession has responded nobly to the call of humanity, but more are required. YOU ARE NEEDED. The following questions and answers will aid you in your decision:

INFORMATION RELATING TO BOTH ARMY AND NAVY.

(1) Q. How do I apply for a commission in the Medical Reserve Corps?

A. Write to the Surgeon General of the Army or Navy, the Council of National Defense, or for the Army appeal direct to an examiner for the Medical Reserve Corps. Detailed information will then be furnished.

(2) Q. What is the character of examinations?

A. Fill out the application form supplied by the Army, or in the form indicated by the Navy, then submit to a physical and professional examination. All papers, when completed, will be forwarded by the examiner to the Surgeon General's Office with a definite recommendation as the result of the physical and medical findings.

(3) Q. What provisions are made for myself and family in the event of injury or death?

A. Allowances will be made in case of injury or death according to the War Risk Insurance Act. These are arranged according to a schedule of the number of the officer's dependents.

(4) Q. What will be the cost of equipment?

A. The average cost of the necessary equipment in the Army is about $250, although even this amount is not absolutely necessary. The Navy provides an allowance of $150 to cover this cost. This is paid to the officer upon his first reporting for duty.

(5) Q. What is the time allowed for reporting after notification that I will be assigned to duty?

A. Fifteen days, with few exceptions, and then only when necessity demands.

(6) Q. What will I do when orders are received?

A. Obey explicitly.

(7) Q. What will be the character of orders received?

A. You will probably be sent to a medical military training camp for instruction.

(8) Q. How soon will the call for active duty be received?

A. If a request for immediate service is made, it will probably be granted. If you do not request immediate service, you will be given 15 days in which to arrange your home affairs from the time you receive the notification that you will be assigned to duty until the day you are to report. However, do not discontinue the practice of medicine until you are notified that your services are needed.

(9) Q. How can I secure immediate service?

A. Write to the Surgeon General of the Army or Navy, Washington, D. C., making such a request, stating at the same time your qualifications for special service.

(10) Q. Is there an urgent need for medical officers now?

A. The present inactive Reserve Corps of both Army and Navy is practically negligible and consists of officers enrolled but engaged in hospital internships and other absolutely necessary present duties, with which there is no desire to interfere any more than is necessary, and of those retained by different departments for special duties. The Reserve, therefore, has been exhausted and it has been estimated that there is an absolute need now for 1,000 more medical officers in the Navy and 5,000 more medical officers in the Army.

(11) Q. What will be the character of service?

A. Every effort is made so far as possible to place an officer where his special talents will be best utilized, and his wishes with regard to such assignments are accorded every consideration.

(12) Q. When shall I discontinue the practice of medicine?

A. Not until notice is received from the Surgeon General to be prepared for active duty on or about a certain date.

INFORMATION RELATING TO ARMY.

(13) Q. What are the requirements for a commission?

A. An applicant for appointment in the Army must be a citizen of the United States between 22 and 55 years of age, a graduate of a reputable medical school legally authorized to confer the degree of doctor of medicine, he must have qualified to practice medicine and be in the active practice of his profession.

(14) Q. How do I accept a commission?

A. A notice will be received from the Adjutant General of the Army stating that you have been recommended for a commission. Sign the oath of office, take an affidavit before a notary public, and send it with a note of acceptance of commission to the Adjutant General of the Army, Washington, D. C., and at the same time send a note to the Surgeon General of the Army stating that you have accepted your commission as (here note the rank). In the same letter request immediate service, if desired.

(15) Q. When do I become an officer of the Medical Reserve Corps?

A. When the oath of office together with a note stating that you will accept the commission offered in the Army is received and is of record in the Office of the Adjutant General of the Army, Washington, D. C.

(16) Q. For what length of time do I volunteer?

A. In the Army, 5 years.

(17) Q. What pay do officers receive?

A. Lieutenant, $2,000; captain, $2,400; major, $3.000; plus 10 per cent for foreign service. Under the new act just signed by the President, if quarters are not available as a place of abode for wife, child, or dependent parent, each commissioned officer of the Army shall also be paid commutation at the rate authorized by law—first lieutenant, $432; captain, $576; major, $720.

(18) Q. What are the expenses for field service?

A. From $25 to $50 per month.

(19) Q. How many medical officers were on active duty April 26, 1918?

A. *Army.*

Regular Medical Corps	843
Medical Reserve Corps	16,359
Medical Corps, National Guard	1.204
Medical Corps, National Army	111

(20) Q. What is the average number of physicians in each thousand discharged from the Medical Reserve Corps of the Army, and for what reasons?

A. Physical disability, 31; inaptitude, 13; domestic and community needs, 4; deaths, 3; resignations, 10.

INFORMATION RELATING TO NAVY.

(21) Q. What are the requirements for a commission?

A. An applicant for appointment in the Navy must be a citizen of the United States, graduate of a reputable medical school, between the ages of 21 and 44 years; the grade given is assistant surgeon, with rank of lieutenant, junior grade (corresponding to first lieutenant in the Army).

(22) Q. How do I accept a commission?

A. A notice will be received from the Surgeon General of the Navy stating that you have been recommended for a commission. Sign the oath of office, which will be supplied, take an affidavit before a notary public, and forward it with a note of acceptance of commission to the Surgeon General of the Navy, Washingtin, D. C. In the same letter request immediate service, if desired.

(23) Q. When do I become an officer of the Medical Reserve Corps?

A. When the oath of office together with a note stating that you will accept the commission offered in the Navy is received and is of record in the Bureau of Navigation, Navy Department, Washington, D. C.

(24) Q. For what length of time do I volunteer?

A. In the Navy, 4 years or for the duration of war.

(25) Q. How many medical officers are on active duty?

A. *Navy.*

Regular Medical Corps	844
Medical Reserve Corps Medical Reserve Force Medical Corps, Naval Militia Retired Medical Officers	1,150

INFORMATION RELATING TO REGULAR ARMY.

(1) Q. How do I apply for a commission in the Regular Medical Corps of the Army?

A. Write to the Surgeon General, U. S. Army, Washington, D. C., and detailed information will be furnished.

(2) Q. Are there any vacancies in the Regular Medical Corps of the Army?

A. 1,100.

(3) Q. What is the character of questions?

A. Full information concerning the examination may be procured upon application to the "Surgeon General, U. S. Army, Washington, D. C." The essential requirements to securing an invitation to report for examination are that the applicant shall be a citizen of the United States, between 22 and 32 years of age, a graduate of a medical school legally authorized to confer the degree of doctor of medicine, of good moral character and habits, and shall have had at least one year's postgraduate hospital internship.

(4) Q. What commission will I receive?

A. Those applicants who successfully pass the examination are commissioned first lieutenants in the Medical Reserve Corps, and sent to either the Army Medical School in Washington or to a training camp for a course of instruction, covering a period of approximately three months, during which time they draw pay and allowances of their grade. If, at the close of their instruction, they pass the final examination, and are favorably recommended, they are commissioned first lieutenants in the Medical Corps of the Regular Army.

(5) Q. What is the pay?

A. To each rank is attached a fixed annual salary, which is received in monthly payments, and this is increased by 10 per cent for each period of 5 years' service until a maximum of 40 per cent is reached. A first lieutenant receives $2.000 per annum, or $166.66 monthly. At the end of 5 years (*during the period of the war, at the end of one year*) he is promoted to captain, subject to examination, and receives $2,400 a year, with an increase of 10 per cent after 5 years' service, making $2,640, or $220 per month. After 10 years' service the pay would be $2,880 annually, or $240 per month. The pay attached to the rank of major is $3.000 a year, which, with 10 per cent added for each 5 years' service, becomes $3,600 after 10 years' service, $3,900 after 15 years' service, and $4,000 after 20 years.

(6) Q. What are my prospects for advancement?

A. During the existing emergency a first lieutenant of the Medical Corps, U. S. Army, is required to complete only one year's service, instead of the 5 years provided for by the act of June 3, 1916, to become eligible for promotion to the grade of captain, subject to examination.

(7) Q. What are the arrangements for retirement?

A. Officers of the Medical Corps are entitled to the privilege of retirements after 40 years' service, or at any time for disability incurred in the line of duty. On attaining the age of 64, they are placed on the retired list by operation of law. Retired officers receive three-fourths of the pay of their grade (salary and increase) at the time of retirement.

VOLUNTEER MEDICAL SERVICE CORPS OF THE UNITED STATES.

RULES OF ORGANIZATION.

I. *Name.*—The name of the organization shall be the Volunteer Medical Service Corps of the United States.

II. *Object.*—1. The object of the Corps shall be to establish an emergency medical organization to perform,

when required, such civic and military duties as are not provided for.

2. Services of members will be called for and rendered in response to requests to a Central Governing Board from the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, the General Medical Board of the Council of National Defense, or from other duly authorized departments or associations.

III. *The Corps.*—The Corps shall consist of all members of the organization. The general management of the Corps shall be vested in a Central Governing Board.

IV. *Central Governing Board.*—The Central Governing Board shall be a committee of the General Medical Board, Council of National Defense.

V. *Officers.*—The officers of the Corps shall be a president, a vice-president, and a secretary, and shall be appointed from among the members of the Central Governing Board. These officers shall constitute the executive committee of the Central Governing Board, and shall direct the activities of the Corps.

VI. *State Governing Boards.*—1. The State Governing Boards shall consist of the members of the State Committees, Medical Section, Council of National Defense. The State Committees shall select, subject to the approval of the Central Governing Board, five of their members who are eligible for election in this Corps to act as the executive committee of the Volunteer Medical Service Corps in the respective States.

2. The duties of the executive committee of the State Governing Board shall be to consider applications for membership in the Corps from the respective States and to submit recommendations regarding these applications to the Central Governing Board.

3. The State Governing Board shall aid in the work of the executive committee and perform such other duties as may hereafter be deemed essential by the Central Governing Board to accomplish the purpose for which the Corps was created.

VII. *Membership.*—1. Such physicians shall be eligible for membership in this Corps as would be accepted in the Medical Reserve Corps were it not for—

(a) Physical disability.
(b) Over age (55).
(c) Essential public need.
(d) Essential institutional need.
(e) Dependents.

2. Women physicians are eligible.

3. Application for membership in the Volunteer Medical Service Corps shall be made upon blanks furnished for that purpose by the Central Governing Board. The completed form shall be returned to the Central Governing Board for proper classification according to training and special fitness.

VIII. *Method of Election.*—1. The members of the Corps shall be graduates in medicine who are licensed to practice medicine in their respective States, who have made application for membership, who meet the qualification requirements that are now or shall from time to time be established by the Central Governing Board, and who shall be elected to membership by the Central Governing Board.

2. Each physician elected to membership in the Corps shall be designated as a member of the Volunteer Medical Service Corps.

3. It shall be the duty of each member of the Volunteer Medical Service Corps to notify the Central Governing Board when eligibility to the Corps ceases to exist.

IX. *Insignia.*—1. Members of the Corps shall be authorized and encouraged to wear the insignia of the Corps.

2. The insignia may be secured by members of the Corps under such regulations as may be determined upon by the Central Governing Board.

3. The insignia shall not be loaned to any person not a member of the Corps, nor shall it be worn after notification that eligibility to the Volunteer Medical Service Corps has ceased to exist.

X. Any member of the Corps may be expelled for conduct which, in the opinion of the Central Governing Board, is derogatory to the dignity of the Corps or inconsistent with its purposes.

XI. *Authorization.*—The organization and insignia have been authorized by the Council of National Defense.

UNCLE SAM'S INSURANCE FOR SOLDIERS AND SAILORS.

ANSWERS TO QUESTIONS YOU WILL ASK.

WHAT IT IS.

1. Q. By whom is this insurance offered?

A. By the United States Government, as authorized in an act of Congress for that purpose approved October 6, 1917.

2. Q. What security is back of this contract of insurance?

A. The United States Government.

3. Q. Is it the only protection furnished by the Government to its soldiers and sailors?

A. No. The Government has provided, in addition, compensation for death or injuries or disease suffered in line of duty.

4. Q. The insurance, then, is in addition to compensation?

A. Yes; and they are entirely independent of each other.

5. Q. Does insurance interfere with service or retirement pay?

A. No; the right to insurance is independent of the right to service or retirement pay.

6. Q. Am I compelled to take insurance?

A. No; you may take it or not, as you see fit. The Government recommends it but does not compel you to take it.

INSURED—BENEFICIARIES.

7. Q. Who can be insured?

A. When engaged in active service under the War Department or Navy Department, any of the following can be insured:

(1) Commissioned officers.

(2) Enlisted men (meaning a person, male or female, enlisted, enrolled, or drafted into active service in the military or naval forces of the United States, including noncommissioned and petty officers and members of training camps authorized by law).

(3) Members of the Army Nurse Corps (female) and members of the Navy Nurse Corps (female).

8. Q. Who can be named as beneficiary?

A. Any one or more of the following may be named: Wife, husband, child, grandchild, brother, sister, adopted brother, adopted sister, stepbrother, stepsister, parent, grandparent, or step-parent of the insured, and parent, grandparent, or step-parent of the insured's wife or husband.

9. Q. Can I name as a beneficiary anyone other than those named in No. 8; for instance, a trustee or guardian or the legal representative of some one in the permitted class or my estate?

A. No; only those in the permitted class may be named. In case a minor or person mentally incompetent is named as beneficiary payment will be made to a guardian or some other person legally vested with the responsibility or care of the beneficiary.

10. Q. Can I name as beneficiary a person who is not a citizen of the United States or one who resides in another country?

A. Yes. If such beneficiary is in the permitted class and if he be resident in enemy territory, payment will be subject to the provisions of the "Trading with the Enemy Act."

11. Q. Can the beneficiary be changed?

A. Yes; within the permitted class, at any time in writing and subject to the regulations of the Bureau of War-Risk Insurance. (See "Final," p. 9.)

BENEFITS.

12. Q. What benefits does this insurance give to the insured?

A. $5.75 per month for each $1,000 of insurance payable in the event of total and permanent disability as long as the insured lives and is so disabled.

13. Q. What benefits does it give to my beneficiary?

A. In case of your death each $1,000 of insurance will pay to the beneficiary $5.75 per month for 240 months, less any payments made to the insured for total and permanent disability.

14. Q. Can I have the benefits paid in a lump sum?

A. No; benefits can only be paid in 240 monthly installments.

15. Q. Does it pay for death or total and permanent disability from illness as well as injury?

A. Yes.

16. Q. Must the injury or illness be suffered while in the line of duty?

A. No; insurance protection is not limited by any provision as to line of duty. This is in direct contrast to the rights as to compensation. (See questions 3 and 4.)

17. Q. Must the injury or illness be suffered while in the service?

A. No; if you continue to pay premiums you are protected, even though you may leave the service.

18. Q. If payment of premium is not made on the exact day when it falls due will insurance lapse?

A. No; it is subject to 31 days' grace, during which time it will remain in full force and effect.

19. Q. If insurance lapses, can I have it revived or reinstated?

A. Yes; at any time within six months after lapse, on compliance with the terms and conditions as may be specified in the regulations of the Bureau.

20. Q. If I leave the service, do I lose my insurance?

A. No; you may carry insurance with the Government even though you leave the service, but in order to do so you must change to another form within five years after the close of the war.

THE APPLICATION.

21. Q. What must I do to become insured?

A. Make written application, stating your name, military organization, date of last entry into active service, age, the amount of insurance desired, and if you wish to name persons to whom you wish it paid in the event of death, give the name of such beneficiaries, using their given name. Example: Jane Elizabeth Smith, do not write it Mrs. John Smith, or Mrs. J. E. Smith.

22. Q. Will application blanks be furnished?

A. Yes. They may be procured from the Bureau of War-Risk Insurance, Washington, D. C.; from your commanding officer; or the insurance officer of your organization.

23. Q. Must I name a beneficiary?

A. You need not name a beneficiary. The law provides that where no beneficiary is named the insurance, in case of death, will be paid to those in the permitted class who would be entitled to your personal property should you die without making a will.

24. Q. If I do not name a beneficiary now may I do so later?

A. Yes; at any time by written designation sent to the Bureau of War-Risk Insurance, Washington, D. C.

THE PREMIUM.

25. Q. What will it cost?

A. See table of rates on last page.

26. Q. How much can I take?

A. Any amount from $1,000 to $10,000 (in multiples of $500).

27. Q. For how long will the privilege of taking insurance last?

A. For only 120 days after enlistment or entry into active service unless you were in the service on October 15, 1917, in which event you may apply at any time within 120 days from that date. The last day of which 120 days is February 12, 1918.

28. Q. If I take less than $10,000, can I increase it after my 120 days have expired?

A. No; you can only apply within the 120 days and can not increase your insurance after that time. Up to that time you may increase it to not more than $10,000.

29. Q. If I take $10,000 or any other amount, can I drop part of it at any time?

A. Yes.

30. Q. How can my premiums be paid?

A. By deduction from your pay, by deduction from any deposit with the Government, or paid direct to the bureau by yourself or some one for you. To avoid lapse it is recommended that deduction from pay be authorized.

31. Q. For how long must my premium be paid in advance?

A. You may pay monthly or for any longer period.

32. Q. Will my premium always be the same?

A. No; it increases annually in accordance with premium table (question 25, see last page) until you change to another form after the war, when the premium will depend upon the plan then chosen.

THE PLAN OF INSURANCE.

33. Q. What form of insurance is it?

A. Annual renewable term insurance for the period of the war. Change to the usual forms of insurance on some other plan may be made within five years after the close of the war.

34. Q. Can I carry my insurance after the war?

A. Yes, in its present form for a period of five years, but within such five years you must change it to another form which can be done without regard to your then physical condition. No medical examination will be required for the change.

35. Q. Will the permanent insurance after the war continue with the Government?

A. Yes.

36. Q. How are the expenses of handling the insurance paid?

A. By the Government.

37. Q. Will the cost to me be increased by the losses due to war?

A. No. Any losses in excess of premiums received will be borne by the Government.

38. Q. What form of insurance can I change to after the war?

A. Usual forms, including ordinary life, 20-payment life, and endowment.

39. Q. Has this insurance during the war a cash value or loan value?

A. No.

40. Q. Will permanent forms of insurance after the war have cash and loan values?

A. Yes.

NOT ASSIGNABLE.

41. Q. Can people to whom I owe money collect such debts out of my insurance?

A. No. This insurance can not be attached, assigned, or otherwise taken by creditors.

42. Q. Does the Government provide automatic insurance?

A. Yes; for those who may be totally and permanently disabled or who may die without having applied before February 12, 1918, the Government has provided insurance in amount of $25 per month payable to a wife, during her widowhood; child, or widowed mother. It should be borne in mind that this insurance is payable to a more restricted class and does not last beyond February 12, 1918, and that on leaving the service the right to apply ceases. Automatic insurance should not therefore induce you to delay making application.

ON LEAVING THE SERVICE.

43. Q. If while in the service I become insured, do I lose my insurance when I leave the service?

A. No; you may carry the insurance even though you leave the service, but you must change it to another form within five years after the close of the war in order to continue it beyond that time.

FINAL.

44. Q. I am single and have no dependents; why should I take insurance?

A. (1) Because the insurance is payable to you in monthly installments of $5.75 for each $1,000 of insurance should you become totally and permanently disabled.

(2) You may at some later date acquire by marriage a dependent whom you will be glad to make your beneficiary.

(3) Then, too, you may not be able to pass an examination for life insurance in a regular company (see answer to No. 34).

MONTHLY PREMIUMS FOR EACH $1,000 OF INSURANCE.

[Each $1,000 of insurance is payable in installments of $5.75 per month for 240 months; but if the insured is totally and permanently disabled and lives longer than 240 months, the payments will be continued as long as he lives and is so disabled.]

Age	Monthly Premium	Age	Monthly Premium
15	$0.63	41	$0.82
16	.63	42	.84
17	.63	43	.87
18	.64	44	.89
19	.64	45	.92
20	.64	46	.95
21	.65	47	.99
22	.65	48	1.03
23	.65	49	1.08
24	.66	50	1.14
25	.66	51	1.20
26	.67	52	1.27
27	.67	53	1.35
28	.68	54	1.44
29	.69	55	1.53
30	.69	56	1.64
31	.70	57	1.76
32	.71	58	1.90
33	.72	59	2.05
34	.73	60	2.21
35	.74	61	2.40
36	.75	62	2.60
37	.76	63	2.82
38	.77	64	3.07
39	.79	65	3.35
40	.81		

WAR NOTES

Dr. E. L. Parmenter of Mondovi, now at Camp Travis, is an example of rapid promotion of a country physician after entering service and his case should re-assure the man who hesitates at accepting a Lieutenant's commission. Dr. Parmenter entered as a First Lieutenant May 29th, 1917. He won his majority on November 15th and on March 15th was made a Lieutenant Colonel.

Capt. G. A. Bading, M. R. C., former mayor of Milwaukee, has been ordered to Base Hospital No. 29, Camp Cody, and expects to leave for France shortly.

Dr. G. H. Dickinson, who enlisted as a private in the Home Guard last October has applied for and received a commission in the M. R. C.

Dr. G. A. Powless, physician at the Oneida reservation, has been commissioned a first lieutenant and been ordered to overseas duty. Dr. Powless estimates the number of Indians in the army at something in excess of 50,000. There are 65 Oneidas from our own reservation.

The many friends of Dr. C. N. Steusser of Alderly gave him a very pleasant surprise party before leaving for service at Fort Oglethorpe.

Lieut. Col. E. L. Parmenter of Mondovi, recently occupied the pulpit of the McKinley Avenue Methodist Church at San Antonio.

Dr. C. E. Lauder of Viroqua has received orders to report at Ft. Sheridan.

Dr. T. C. H. Abelmann of Watertown has been commissioned a First Lieutenant and ordered to Pittsburgh for a special course in surgery.

Dr. W. J. Thompson of Portage, visited his home May 20th on a few days leave of absence before leaving for service abroad.

Major Henry D. Jump of the Council of National Defense, Washington, D. C., has recently spoken to medical and lay audiences at La Crosse, Madison, Milwaukee and Beloit.

Dr. Benjamin Fosse of Beloit has been home on a few days leave of absence. He was tendered a reception by the profession of his home city and presented with a handsome gold pencil.

Dr. Nelson M. Black of Milwaukee, who has been assigned for the past year to the Surgeon General's office, as head of the Department of Ophthalmology, has been promoted to the rank of lieutenant colonel.

Lieut. S. Van Heeke of Merrill, has been ordered to Ft. Riley. His leave taking was the occasion of a patriotic demonstration by the people of Merrill.

Drs. R. E. Davies and W. T. Murphy, both of Waukesha in the service, were home to testify in the Grace Lusk trial.

Under direction of Adjutant General Holway, Dr. Daniel S. MacArthur of La Crosse is proceeding with the organization of a sanitary detachment for the state guards.

Lieut. J. E. B. Ziegler of Eau Claire left on May 11th to report for instruction at the Mayo Clinic.

Dr. J. R. Longley of Fond du Lac, who has been stationed at Camp Custer, has been promoted to a Majority.

Dr. Roy J. Leutsker of Antigo, who is to graduate at the Northwestern in June, has joined the Naval Medical corps and been assigned to the Great Lakes Training Station.

Several large Milwaukee homes have lately been suggested as possible locations for reclamation hospitals for Wisconsin soldiers as they are returned from the front.

After months of separation the Drs. Trowbridge, one in the Army and one in the Navy, met "somewhere in France," neither being aware of the location of the other.

Dr. G. W. Krohn of Oconto Falls, recently discharged from service because of physical disability, has been reappointed surgeon for the C. & N. W. Ry. Company.

Dr. J. G. Hoffman, Hartford, has been home on a few days leave from Ft. Riley. He left on May 3d for Camp Merritt, New Jersey.

Dr. Lyman Steffen of Antigo writes that he is seeing service at the front and dodging enemy shells and air bombs.

Dr. C. N. Sonnenburg of Sheboygan has received his commission and left on orders May 17th for Washington.

Capt. C. A. Baer, formerly of Milwaukee, writes of the terrible suffering of French refugees.

Dr. Geo. H. Conklin of Superior, who has been in training at Ft. Riley since February, has left for an eastern port.

Dr. L. M. Bachhuber of Mayville, who was rejected for service in the M. R. C. on physical grounds, has received appointment in the volunteer medical service corps.

The United States Public Health Service is in need of medical officers for field duty in connection with the sanitation of several civil sanitary districts. Men physically disqualified from the Medical Reserve Corps are eligible for these positions, providing they are not suffering from complaints that would seriously interfere with the performance of their duties.

Dr. Edward Evans of La Crosse, chairman of the Wisconsin Committee, Medical Section, Council of National Defense, and former president of the State Medical Society, is an example of the man over age who persists and finally receives an assignment for duty over seas. Unable to secure a commission in the M. R. C., he offered his services to the American Red Cross and will leave shortly for an executive position in France. The Doctor has two sons in the service and one daughter who is with Milwaukee Base Hospital No. 22.

Dr. E. R. Murphy of Antigo received orders May 4th to report for duty at Bellevue Hospital, New York.

Dr. Justus Sutherland of Brodhead has been commissioned a first lieutenant in the M. R. C.

The physicians of Ashland, Bayfield and Iron Counties gave a banquet on April 26th at the Elk's Club House, Ashland, in honor of their members who have joined the Reserve Corps.

Lieut. L. C. Soudel, stationed at Ft. Ethan Allen, Vermont, visited his parents in Milwaukee early in May on leave of absence.

Dr. L. M. Pearson of Tomahawk left late in April for duty at Ft. Riley. The doctor was tendered a banquet on the eve of his departure.

The secretaries of the various State Medical Societies met in Chicago at the A. M. A. headquarters May 1st to consider ways and means of co-operation with the War Department in securing enlistments for the M. R. C. A resolution was passed requesting the President of each society to appoint a war committee of three members to carry on the work in their state. President Windesheim of Kenosha appointed Dr. J. S. Evans of Madison, Dr. F. Gregory Connell of Oshkosh and Dr. Rock Sleyster of Waupun as such a committee for Wisconsin.

Dr. Emmett Bowen of Watertown is now located at the Base Hospital at Camp Grant, Illinois.

Quotas assigned to this and neighboring states to meet the demand of the Surgeon General's department by July first are as follows: Michigan 100, Minnesota 70, Montana 20, North Dakota 50, South Dakota 45, Wisconsin 100, Wyoming 30.

Dr. Max Staehle of Manitowoc was ordered to Ft. Oglethorpe May 1st.

Dr. E. F. McGrath of Appleton, who has been in training at Ft. Riley, was home late in April on a ten day leave of absence.

A farewell party was given Dr. R. L. MacCormack of Alma Center on April 26th before he left for service.

Dr. A. L. Kyllo of Grantsburg was tendered a farewell reception at the Antlers' Hotel, April 22, on leaving for service at Ft. Riley. His brother, Dr. J. C. Kyllo, is already in training at the Fort.

Dr. C. O. Hertzman of Ashland was ordered to Ft. Riley April 20th. It is later reported that Dr. Hertzman has been returned home, having been found physically disqualified.

Dr. J. P. Harkins of Forest Junction has left for militarly service.

Dr. A. C. Borchardt of New London was ordered into service April 25th.

Dr. R. B. Quinn of Darlington has been commissioned as first lieutenant in the Medical Reserve Corps.

BASE HOSPITAL No. 22 LEAVES FOR FRANCE.

At 4:25 P. M., May 19th, Base Hospital No. 22, which has been mobilized and quartered at the Auditorium, Milwaukee, since January 5th, marched to the Union Station and entrained for "somewhere in France." Base Hospital No. 22 is purely a Milwaukee organization. Practically all of its members are men of Milwaukee or the state. It was organized by the Milwaukee Red Cross chapter which equipped it with everything from heavy war ambulances to surgical dressings. It has two hundred and one men and about twenty-six officers and it will care for one thousand patients. More than one hundred nurses who are part of the unit are finishing their training in the east and will join the base hospital on board the ship that will carry it to France. It required six passenger coaches and fifteen freight cars to move the unit. Wisconsin is proud of its first contribution of a base hospital completely equipped and ready for work with a personnel of our best medical men, in whom we have explicit confidence. Its officers are as follows:

Col. Thomas J. Kirkpatrick.

Majors—Otho A. Fiedler, Curtis A. Evans, Robert Curtis Brown, Thomas L. Gore.

Captains—Lindsay Denison, John W. Means, John M. Beffel, Henry B. Hitz, Herbert Walker, Oscar E. Lademan, Philip F. Rogers, Francis A. Thompson, Ralph T. Gilchrist.

First Lieutenants—Harry R. Foerster, Stephen Campbell, William J. Egan, Ulrich Senn, Jeffrey J. Brook, George M. Fitzgerald, John E. Reuth, Orville A. Little, John W. Smith, Francis B. McMahon, Edward L. Tharinger, George D. Siewert.

Chaplain—Paul B. Jenkins.

RECENT ORDERS ISSUED TO WISCONSIN PHYSICIANS IN SERVICE.

To Camp Gordon, Atlanta, Ga., base hospital, from Boston, Lieut. John W. Hansen, Milwaukee.

To Camp Kelly, San Antonio, Texas, for duty, from Camp MacArthur, Lieuts. George W. Harrison, Ashland; James H. Fowler, Lancaster.

To Edgewood, Md., base hospital, Lieut. Emil H. Sutter, Milwaukee.

The following orders have been revoked: To Camp Cody, Deming, N. M., base hospital, Capt. Gerhard A. Bading, Milwaukee. To Fort Riley for instruction, Lieut. Knute A. Ruethin, Ridgeland.

To New York City, Bellevue Hospital, for instruction, and on completion to Camp Dix, Wrightstown, N. J., base hospital, Lieut. Edwin R. F. Murphy, Antigo.

To Philadelphia, Pa., University of Pennsylvania, for instruction and investigation, and on completion to his proper station, Major Robert H. Ivy, Milwaukee.

To Pittsburgh, Pa., for instruction, and on completion to Camp Dix, Wrightstown, N. J., base hospital, Lieut. Theodore C. H. Abelmann, Watertown. On completion to Camp Meade, Annapolis Junction, Md., base hospital, Lieut. Mordahl O. Gunderson, Beloit.

To Army Medical School for instructions, Lieuts. Robert L. MacCormack, Alma Center; John P. Harkins, Forest Junction.

To Camp Cody, Deming, N. M., base hospital, from Camp Cody, Capt. Gerhard A. Bading, Milwaukee.

To Camp Dodge, Des Moines, Iowa, base hospital, from Fort Riley, Lieut. Roy F. Breeden, Richland Center.

To Camp Laurel, Laurel, Md., for duty, from Camp Joseph E. Johnston, Lieut. Leon H. Flancher, Milwaukee.

To Camp Lee, Petersburg, Va., base hospital, from Camp Lee, Lieut. Cornelius J. Corcoran, Milwaukee.

To Camp Logan, Houston, Texas, for duty, from Camp MacArthur, Lieut. Ivan S. Pippan, Excelsior.

To Camp Meade, Annapolis Junction, Md., to examine the command for mental and nervous diseases, from Camp Devens, Lieut. Chas. C. Rowley, Winnebago.

To Chicago, Ill., Presbyterian Hospital, for instruction, and on completion to his proper station, from Camp Custer, Capt. Albert A. Maurer, La Crosse; from Camp Zachary Taylor, Capt. Burt Excott, Berlin. On completion to Camp Pike, Little Rock, Ark., base hospital, Lieut. Earl L. Baum, Milwaukee.

To Fort Riley for instruction, Capts. Carl O. Hertzman, Ashland, August L. C. Burchardt, New London; Lieuts. Herman M. Lynch, Allentown; Henry A. Sincock, Odanah, Knute A. Ruethin, Ridgeland, Louis M. Pearson, Tomahawk.

To Mount Clemens, Mich., Selfridge Field, Signal Corps Aviation School, from Mineola, Capt. Edwin G. Festerling, Reedsville.

To Camp Beauregard, Alexandria La., as member of a board of medical officers for the special examination for tuberculosis, from Fort Oglethorpe, Capt. Anfin Edgahl, Menominie.

To Camp Dodge, Des Moines, Iowa, base hospital, Capt. Arthur F. Lyon-Campbell, Florence.

To Camp Lee, Petersburg, Va., for duty, Lieut. Rudolph C. Pfeil, Milwaukee.

To Camp Pike, Little Rock, Ark., for duty, Lieut. Richard A. Dreyer, Wheeler.

To Camp Shelby, Hattiesburg, Miss., as assistant to camp surgeon, from West Point, N. Y., Lieut. Arthur D. Smith, Gilmanton.

To Cape May, N. J., base hospital, from Camp Pike, Capt. J. Gurney Taylor, Milwaukee.

To College Station, Texas, for duty, from Houston, Capt. Hubert S. Steenberg, Milwaukee.

To Fort Riley for instruction, Capts. Arthur H. Winter, Tomah; Sylvester R. Hutchins, Whitehall.

To Jefferson Barracks, Mo., for temporary duty, and on completion to his proper station, from Camp Pike, Lieut. Frank H. Russell, Neenah.

To Fort Myer, Ga., for duty, Lieut. Clarence N. Sonnenburg, Sheboygan.

To report by wire to the commanding general, Central Department, for assignment to duty, Capt. John R. Eastman, Kenosha.

To Fort Oglethorpe for instruction, Capt. Max Staehle, Manitowoc; from Fort Sill, Capt. William E. Kramer, Milwaukee; from New York City, Lieut. Adam L. Curtin, Milwaukee.

To Fort Riley for instruction, Lieuts. Albert R. Bell, Tomah; William B. Cornwall, Turtle Lake.

To New York City, Bellevue Hospital, for instruction, and on completion to his proper station, from Camp Wadsworth, Lieut. Erwin G. Linkman, Milwaukee.

To Ann Arbor, Mich., Psychopathic Hospital, for intensive training, from Camp Dodge, Capt. John M. Couley, Oshkosh.

To Boston Mass., Harvard Graduate School of Medicine, for instruction, and on completion to his proper station, from Camp Pike, Capt. Homer Sylvester, Montfort.

To Camp Gordon, Atlanta, Ga., base hospital, from Boston, Lieut. John W. Hansen, Milwaukee.

To Camp Lewis, American Lake, Wash., base hospital, from Camp Cody, Lieut. Harry E. Gillette, Packwaukee, from Fort Riley, Lieut. George E. Lindow, Watertown.

To Fort Logan, Colo., for temporary duty, and on completion to his proper station, from Camp Taliaferro, Lieut. Paul M. Clifford, Green Bay.

To Fort Oglethorpe for instruction, Capts. William D. Harvie, Oshkosh; Argo M. Foster, Racine; Lieuts. Frank A. Boeckmann, Greenwood; Howard M. Ripley, Kenosha; Cornelius N. Stuesser, Oconomowoc.

To Fort Riley for instruction, Lieut. Ingebrect Jerdee, Madison.

To New York City, Cornell Medical College, for instruction in military roentgenology, from Fort Riley, Lieuts. Earle F. McGrath, Appleton; Carl C. Birkelo, Rosholt; Thomas F. Laughlin, Winneconne.

To report by wire to the commanding general, Central Department, for assignment to duty, Capts. Ernest C. Grosskopf, Milwaukee; Charles E. Lauder, Viroqua.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion to Camp Bowie, Fort Worth, Texas, base hospital, Lieut. John E. B. Ziegler, Eau Claire. On completion to his proper station, from Camp Grant, Lieut. Donne F. Gosin, Green Bay.

The following order has been revoked: To Fort Riley for instruction, Lieut. Albert R. Bell, Tomah.

BOOK REVIEWS

LABORATORY METHODS OF THE U. S. ARMY. Compiled by the Division of Infectious Diseases and Laboratories, office of the Surgeon General. Cloth, 256 pages. Lea & Febiger, Philadelphia and New York. Price, $1.50.

This is number six of the Lea and Febiger War Manuals. It has been compiled by members of the Surgeon General's staff and members chosen from the M. R. C. The section on Quantative Analytical Methods which is of special value was written by Dr. Donald D. Van Slyke. The collection and shipment of specimens, the making of solutions and stains, the routine methods of clinical pathological work, are all given without unnecessary detail. Bacteriological methods and the sanitary examination of milk, water and sewage are given as required in army service. It is a valuable little manual for any laboratory and will be of much help to those entering the service.

MEDICAL SERVICE AT THE FRONT. By Lt. Col. John McCombe, C. A. M. C. and Capt. A. F. Menzies, M. C., C. A. M. C. Illustrated. 128 pages. Cloth, $1.25. Lea and Febiger, publishers, Philadelphia and New York.

This is another of the War Manuals just from the press, written by two of our Canadian brothers in the war. A foreword by the Surgeon General of Canada reads: "I can recommend to your favorable consideration and earnest perusal this unpretentious volume. It it hot from hell's gridiron and correct in all details." It describes a division in the front line, tells of the work of the Regimental Medical Officer, thoroughly takes up the subject of the field hospital and the casualty clearing stations. Men entering service should have it.

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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES.

County.	President.	Secretary.
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Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
Brown-Kewaunee	A. O. Olmsted, Green Bay	E. G. Nadeau, Green Bay.
Calumet	W. C. Schmitz, School Hill	E. L. Bolton, Chilton.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	L. H. Prince, Madison	W. H. Sheldon, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	G. C. Nedry, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	G. B. McKnight, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	R. E. Flynn, La Crosse	Jens Rosholt, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Schockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. E. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
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Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. H. Fellman, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	A. R. Bell, Tomah	S. D. Beehe, Sparta.
Oconto	C. W. Stoelting, Oconto	T. C. Clarke, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	E. R. Boyer, Rhinelander.
Outagamie	J. J. Laird, Black Creek	M. J. Sandhorn, Appleton.
Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
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Portage	D. N. Alcorn, Stevens Point	F. A. Marrs, Stevens Point.
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Rock	M. P. Andrews, Beloit	E. B. Brown, Beloit.
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Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	J. W. Lockhart, Oshkosh	E. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Ruckle, Grand Rapids.

SOCIETY PROCEEDINGS

ASHLAND-BAYFIELD-IRON COUNTY

A banquet was held by the Ashland, Bayfield and Iron County Societies at the Elk's Club, Ashland, April 26th, in honor of members who have joined the Reserve Corps.

Those present were Drs. Andrus, Hosmer, Marchessault, O'Brien, Wenzel, Hertzman, Hinrichs, Mills, Smiles and Dodd of Ashland; Hannum of Bayfield; Johnson of Iron River; Ringo of Montreal; Lockhart and Critchlow of Mellen, and Sincock of Odanah.

Drs. Critchlow and Hinrichs gave interesting talks on military training of the Medical Corps at Fts. Riley and Oglethorpe and short talks were given by the members present.

DODGE COUNTY

Dr. D. J. Twohig was the principal speaker at the meeting of the members of the Dodge County Medical Society at the hotel in Minnesota Junction. After dinner, short talks were given by members of the Dodge County Medical body, and a general discussion of the present situation in the medical profession was held.

EAU CLAIRE COUNTY.

The Eau Claire County Medical Society met at the Galloway House, May 27th at 7:30 o'clock P. M. The prgoram was given by Dr. E. H. Ehlert of Minneapolis and Dr. I. F. Thompson of Eau Claire, the former speaking on "New Phylacogens" and the latter on "Quarantine Regulation."

MILWAUKEE COUNTY.

The Milwaukee Medical Society held a joint meeting with the Wisconsin Surgical Association at a dinner in the Hotel Wisconsin Thursday evening, May 9th. Dr. V. A. Mason of Marshfield spoke on Surgical Efficiency and Dr. M. E. Fairfield of Green Bay spoke on Surgical Treatment of Prolapsus Uteri.

NINTH COUNCILOR DISTRICT.

Dr. J. P. Christofferson of Waupaca was elected president of the Ninth Councilor District Medical Society at the annual meeting held in the public library in Stevens Point May 15th. Dr. C. von Neupert, Jr., was elected vice-president and Dr. W. G. Sexton of Marshfield, secretary-treasurer. Members were present from Wausau, Merrill, Grand Rapids, Marshfield, Waupaca, New London and Stevens Point. Following a dinner at 6:30 o'clock, a program was carried out in which Dr. D. T. Jones of Wausau, Dr. Carl W. Doege of Marshfield and Dr. F. J. Gaenslen of Milwaukee talked on scientific subjects. The summer meeting of the society will be held in Waupaca next August, the fall meeting at Wausau and the winter meeting at Marshfield.

PORTAGE COUNTY

A meeting of the Portage County Medical Society was held May 1st, in the office of the President, Dr. D. L. Alcorn, Stevens Point. At this meeting, plans were made for entertaining members of the 9th Councilor District Society, which will be held in Stevens Point May 15th. A committee consisting of Drs. E. H. Roger, J. D. Lindores and F. A. Southwick was appointed to arrange for the district meeting.

ROCK COUNTY

The Rock County Medical Society held its annual banquet at the Hotel Hilton, Beloit, Tuesday, May 28th, at 8. P. M. The society was exceedingly fortunate in having secured as speaker of the evening, Major Henry D. Jump of Philadelphia. After the banquet the meeting adjourned to a local theater where Major Jump addressed a lay audience and showed motion pictures of medical work in the war.

WAUKESHA COUNTY

Dr. George E. Peterson, president of the Waukesha County Medical Society, was host at a meeting of the society held on Wednesday at the Municipal Hospital, fourteen being in attendance. Dinner was served at Goff's. Discussions on matters pertaining to the war formed a large part of the program. Several active members were missed at the gathering, having entered army service, while other members have been commissioned and are awaiting call. It was the first meeting of the society in several months.

WISCONSIN SURGICAL ASSOCIATION

The Wisconsin Surgical Society held its fifth annual meeting in Milwaukee, May 8th and 9th. Clinics were given during the days at the various Milwaukee hospitals and on Wednesday night a joint session was held with the Milwaukee County Society. Dr. J. F. Pember of Janesville was elected President to succeed Dr. Horace M. Brown. Dr. J. Hayes of Milwaukee was elected Vice-President and Dr. Daniel Hopkinson was re-elected Secretary and Treasurer. Dr. Horace M. Brown was elected a member of the Board of Regents and Dr. J. V. R. Lyman was re-elected to this body.

NEWS ITEMS AND PERSONALS.

Dr. J. M. Furstman, City Health Commissioner of La Crosse, lectured to the members of the Twentieth Century Club at their regular meeting, May 1st, on "Public Health Insurance."

Miss Amelia Ritchie has resigned from the staff of the Theda Clark Hospital at Neenah to accept the superintendency of the Pasadena, California, hospital.

Dr. O. B. Bock of Sheboygan has purchased the interest of Reuben Pfeiler in the Bock Drug Company.

Governor Philipp has suggested that the new reformatory for women which is nearing completion at Taeheda be converted for the period of the war into a hospital for convalescent soldiers. This plan is meeting with wide approval.

Internment for the period of the war has been ordered for Dr. C. O. Theinhaus, an enemy alien of Milwaukee, who was taken into custody six weeks ago. He has been sent to Ft. Oglethorpe, Georgia. Violation of his permit was the ostensible charge on which he was deprived of his Liberty.

St. Mary's Hospital, Ladysmith, was opened Thursday, May 30th. It is a beautiful new structure, three stories and a basement, erected on a commanding eminence near the river.

A service flag containing 170 stars was unfurled May 24th at the Marquette Medical School with appropriate exercises. It means that 170 Marquette Medical School graduates have entered the service.

The Wisconsin Social Hygiene Society has filed papers of incorporation at Madison. The society plans to combat all forms of social disease among selectmen, especially, and will employ a good speaker and medical authority to tour the state. The society was formed at the request of the surgeon general of the army and navy. Among the incorporators are Health Commissioner George C. Ruhland, Superintendent of Schools M. C. Potter and Judges A. C. Backus and E. T. Fairchild.

Miss Florence Philipp, daughter of the Governor, was a member of the graduating class of the Milwaukee Hospital training school for nurses.

Dr. Simeon H. Sauter, 219 Eleventh St., Milwaukee, had an exciting time with a burglar recently.

With the death of Miss Lucinda W. Rice, a pioneer resident of Madison, the Madison General Hospital Association will come into property valued at sixty thousand dollars.

After a brief debate with but three dissenting votes, the County Board of Supervisors of Milwaukee County decided, on May 28th, to purchase the Schandein property on Twenty-fifth St. and Grand Avenue as the location for the new county hospital. One hundred and fifteen thousand dollars was asked for the site.

As a token of appreciation for his services as secretary to the Milwaukee Medical Society, Dr. Oscar Lotz was presented with a silver tray by the organization at its semimeeting. A committee was appointed to prepare resolutions on the death of Dr. Louis F. Frank, who died on Sunday.

Courses in bacteriology which will prepare students for positions in base hospitals, government laboratories, boards of health and medical schools will be offered in the summer session at the University of Wisconsin.

Wm. Horlick, Senior, of Racine, has offered to donate to that city property on which to build the proposed isolation hospital.

The regents of the University of Wisconsin have recently received gifts totaling $100,000 to be used with a $50,000 appropriation for the construction of a new infirmary for the medical school.

At the recent meeting of the State Homeopathic Association, Dr. Charles F. Brown of Racine was elected president; Dr. Luella Axtell, Marinette, vice-president; Dr. John E. Guy, Milwaukee, treasurer; Dr. S. E. Brown, Milwaukee, secretary; Dr. Jos. Lewis, Milwaukee, censor and Dr. J. A. Pennoyer, Kenosha, necrologist.

Additional X-ray equipment has been installed at St. Agnes Hospital, Fond du Lac.

Dr. Hoyt E. Dearholt lectured in Beloit, May 17th, at the Municipal Court Room on "Tuberculosis in War Time." He spoke under the auspices of the Home Service Bureau of the local Red Cross chapter.

In response to the present demand for adequate nursing care for the civilian sick in Wisconsin, the Milwaukee Society for the Care of the Sick has established a "Bureau of Home Nursing." A six months' course is given students in home nursing under the direction of a graduate nurse with special lectures by doctors and social workers.

Mellen has had a severe epidemic of scarlet fever within the last month.

Dr. L. H. Prince of Madison has been appointed by the State Board of Control as superintendent of the State Public School at Sparta to succeed Dr. J. F. Brown, resigned, who has removed to Kankakee, Illinois, to engage in the manufacture of surgical dressings. The selection of Dr. Prince for this position is a most happy one, and a splendid tribute to him was published in the Madison Journal on May 14th.

Appleton has rented the old maternity hospital to be used as an isolation hospital.

The city Council of Beloit will appropriate five hundred dollars for the coming year for the care of the teeth of school children.

The matter of reopening the Oconto County Hospital is being considered and if the plans turn out satisfactorily it will be open by June 1. The hospital will be run during the summer at least and longer if it pays.

Dr. A. T. Lid has been appointed as city physician of Marinette.

John Till, the "plaster" artist, is again in trouble. He was found guilty at a recent term of Circuit Court but has appealed his case. The district attorney of Barron County is determined to drive the quack from that community.

Wisconsin has had 8,100 cases of measles in the last two months.

Dr. and Mrs. A. T. Gregory of Elroy, who have been spending the last three months in the south, have arrived home for the summer.

Five nurses were graduated from the Theda Clark training school at Neenah, May 20th.

The Ashland county board has abolished the offices of county physicians. Under the township system each supervisor will have charge of the poor and needy in his ward or town and where the services of a physician are required the supervisor will call upon the local physician to treat the case and his services will be paid by the county.

The war has caused Marquette University to announce the suspension of its school of pharmacy. Arrangements have been made with the University of Wisconsin which will enable students to attend the Madison institution receiving full credits for their work at Marquette. The school will reopen after the war.

The committee of the last legislature appointed to investigate and report on Health Insurance has been visiting the various industrial centers of the state.

Dr. Tuffley of Boscobel has disposed of his interest in the Brookside Hospital to Drs. Betz and Hayman.

The City Club of Milwaukee has found the South View Isolation Hospital inadequately equipped. They recommend the immediate completion of the building with proper equipment.

Dr. and Mrs. Oscar Lotz of Milwaukee have arrived home from their honeymoon and will reside at the Hotel Carlton until their home on Farwell Avenue is completed.

The enactment of a federal statute making compulsory the registration of every birth throughout the country is the object of a movement recently started. The step follows closely the demand for accurate birth records created by the world war. Practically complete state registration of birth now is enforced in eighteen states, comprising the registration area, to which Wisconsin is one of the most recent entrants.

The corner stone of the new Ashland General Hospital was laid May 12th. Dr. J. M. Dodd was in charge of the ceremonies.

Dr. J. M. Rodermund has been convicted in Circuit Court at Madison on a criminal charge. His license has been revoked. This is not the first time that Rodermund has been in the lime light.

Dr. F. E. Brown, Dr. Edith Bartlett, Janesville, and Dr. Mary M. Hopkins, Oconto, were chosen delegates to the American Institute of Homeopathics' convention at Detroit, June 16 to 23.

That the giving of an anaesthetic under the direction of responsible licensed physician does not require the person to hold a medical license, was the opinion of Attorney-General Owen to Dr. Oscar Lotz of Milwaukee, member of the medical board.

Dr. E. V. Brumbaugh, city bacteriologist of Milwaukee, has accepted a position in a laboratory at Tulsa, Oklahoma.

Dr. Royer of Shawano has returned after spending some time in the south.

REMOVALS

Dr. P. M. Hotvedt, formerly of Cylon, has located in Haugen.

Dr. M. H. Fuller of Chicago has located in Green Bay, limiting his practice to the Eye, Ear, Nose and Throat diseases.

Dr. Roth of Omro has removed to Milwaukee.

Dr. H. A. Newkirck, formerly of Florence, has located at Norway.

Dr. Harper of Merrilan has removed to Alma Center and taken over the practice of Dr. McCornack who has gone into the service.

Dr. O. H. Foerster of Milwaukee has moved his office to 445 Milwaukee St., the Colby-Abbot Building.

Dr. F. E. Cosanke of Ft. Atkinson has removed to Watertown.

Dr. W. C. Jones of Kilbourn has located in a suburb of Birmingham, Alabama.

Dr. John Legnard of Appleton has removed to Houston, Texas.

Dr. Geo. Parke of Sylvan has located in Viola.

Dr. C. A. Lothrop of Ripon will locate in Tomahawk.

MARRIAGES

Dr. Fred E. Church, assistant bacteriologist of Milwaukee County Hospital, to Miss Lilly M. Green, Wauwatosa, May 13.

Dr. Earle X. Thompson, Cudahy, to Miss Dorothy Ferber, a graduate nurse of St. Mary's Hospital, April 17.

DEATHS

Dr. H. L. Barnes of Ripon died in that city April 28th. He was born April 16, 1834, in New York, and came to Green Lake with his parents when seven years of age. He located in Ripon to practice medicine in 1867 and served as a surgeon in the Civil War. He was married to Miss Ellen Cody of Green Lake and is survived by four children, one of whom, Major F. C. Barnes, M. R. C., is in service in France.

Dr. S. P. Jones of Marinette died May 9th at his home in that city of pernicious anaemia. He was born in One-

onta, New York, May 16, 1844, and came to Wisconsin with his parents when a small boy. He graduated at Rush in 1868, was married to Miss Mary Brabant of Chilton the same year, after which he came to Marinette and has resided there continuously since.

Dr. G. A. Heidner died at Long Beach, California, May 3. He practiced at Waubeka, Wisconsin, from the time of his graduation from Rush in 1888 until 1896, after which he moved to West Bend, where he practiced until last November at which time he retired from active practice because of ill health. He was a charter member and first secretary of the Washington County Medical Society, member and ex-president of the Brainard Medical Society, charter member of the Wisconsin Surgical Society, and a member of the Wisconsin State and American Medical Associations.

Dr. Louis F. Frank died at his home, 2300 Grand Avenue, Milwaukee, May 2d, following a short illness. He was sixty-one years of age. Dr. Frank was born in Milwaukee and received his medical education in Europe. On completing this he located in Milwaukee, later specializing in diseases of the skin. He was married early in life to Miss Ella Schandein. For many years he has been active in the educational and musical circles of the city. With his brother John, he was one of the organizers of the Wisconsin Conservatory of Music and served as president of this organization up to the time of his death. He has also been the president of the Milwaukee Musical Society. Inclined to literary work, Dr. Frank a few years ago wrote a history of the lives of the leading physicians of Wisconsin which he published. He had also written a history of the musical organizations of Milwaukee and a history of the Schandein family. Dr. Frank was a member of the Milwaukee County, Wisconsin State and American Medical Associations.

Dr. W. E. Hallock of Juneau, one of Dodge County's oldest and most loved physicians, was injured in a street car accident near Rockford, Illinois, and died as a result of his injuries May 21st. He had been at Camp Grant to visit his grandson in the service. He was seventy-two years old, was a member of Exemption Board No. 2 for Dodge County and had been county physician for thirty years. He was at one time mayor of Juneau. He is survived by one daughter of New York and a grand son. He was a former president of the Dodge County Medical Society and a member of the Wisconsin State and American Medical Associations. His funeral was attended by the members of the Dodge County Society in a body.

CORRESPONDENCE

NOTICE TO NURSES.

The Surgeon General has asked that five thousand more nurses be supplied to the army and navy by June 1, 1918. If the war continues, forty thousand nurses will be needed in the service of the United States by January 1, 1919.

The call is imperative and the need is immediate. The safety of the nation is involved in the way in which nurses accept the responsibility forced upon them in the war. The Red Cross is enrolling the nurses of the country for service. It is the reserve of both the army and the navy, supplying both at home and abroad the number of nurses for which the Surgeon General asks. It is as truly the duty of nurses to serve their country as it is of the soldiers in the trenches.

The emergency must be met by securing the most skillful of nurses to care for the soldiers. Graduate nurses of ability, who are physically able, should volunteer at once for service through the Red Cross. Wisconsin must meet its quota.

The war also calls for greater efficiency in caring for the sick who are at home. The ranks of nurses are being depleted, and the nation appeals to young women to enter the hospitals and fill the gaps left by those who have been called into military service. Let humanity's need call those of finest intellect, high ambition and noble character into the ministry of nursing.

The Wisconsin legislature in the special session of 1918 passed an amendment to the registration law providing, in the schools for nurses, credit for one academic year to all who have completed college courses with laboratory work in Physics, Chemistry and Biology. Wisconsin is one of the first states to make such provision. The amendment also provides that all graduate nurses who have had a two years' course of instruction in a reputable training school connected with a general or special hospital, who make application prior to June 1, 1918, may upon passing examination be granted registration. Let every nurse who is not registered see to it that she avail herself of the opportunity now open to her.

An examination for state registration will be given on June 18, 19, 1918, in Milwaukee. Application blanks and further information as to registration may be obtained from Anna J. Haswell, R. N., Secretary of Committee of Examiners of Registered Nurses, 1610 Jefferson St., Madison, Wis.

Nurses who desire to enroll for Red Cross service should send names to one of the following:

Anna Dastych, R. N., 1027 Jackson St., La Crosse, Wisconsin.

Eleanor M. Regan, R. N., 123 N. Butler St., Madison, Wisconsin.

Regine White, R. N., 320 Sycamore St., Milwaukee, Wisconsin.

Mary Handschin, R. N., 222 N. Main St., Oshkosh, Wisconsin.

LETTER TO SUPERINTENDENTS OF SCHOOLS FOR NURSES IN WISCONSIN AND TO PRESIDENTS OF HOSPITAL BOARDS.

The war has forced upon the nursing profession an emergency which is tremendous, but it is not our part to question whether or not this emergency can be met by us. It must be met. There is no alternative. Nurses must be chosen from every part of our country to go forth to care for the men who are sacrificing all that

life holds dear. Surely there is no question what class of nurses must go to do this work. They must be the best.

The nurses who remain at home are no less doing their patriotic duty, provided they cover just as large a field of service as it is possible to perform. Institutional nurses have placed upon them a responsibility greater than they have ever borne before, but their country's need is their opportunity.

Young women all over the country are planning to study nursing. There is no place for them to do this but in our schools. Shall we then tell them that there is no room? Depleted forces of nurses on the outside make it imperative that the hospitals should open their doors to a great many more patients than ever before. The people must be convinced that when patients need special care, it will be faithfully and skillfully given by pupil nurses. This is the most natural solution to the local need for nurses, and will in every city release about twenty graduate nurses per thousand population. This calls for many more pupil nurses. But we are immediately met with the proposition that housing facilities are such that more cannot be accommodated. Is this true? Is there any city which cannot house and care for many more pupil nurses if it is a patriotic duty? This need can be met by renting houses for them if necessary, and by accepting pupil nurses who can return to their own homes at the close of the day. Many hospitals are doing this. May we appeal to you at once to make provisions for many more pupil nurses?

This is however only one phase of the need. Never was efficiency in nursing so necessary. If the number of pupil nurses is greatly increased, the responsibility and work of the teaching force will be correspondingly increased. Those who give the instruction must be keenly alive to the need for many more thoroughly trained nurses. The pupil nurses of today will be the nurses of tomorrow, and in the work of reconstuction they must be prepared to render valuable service in all departments of nursing.

Requests come daily from young women for information as to the accredited schools for nurses.

Will you not take up with your board the question as to how you may care for more patients, thus releasing from local service many graduate nurses; and also the question of how you may provide for the training of more pupils nurses in your school. It is our belief that many people of your city could be aroused to give to your hospital and school for nurses very enthusiastic and substantial aid.

We do not question your coöperation in this exceedingly important work.

In behalf of the Committee of Examiners,

ANNA J. HASWELL, R. N.,
Secretary.

Put the feet of a hen in hot embers, till the scales or skin thereof be separated or shrunk from the legs, and with the same skin warm, rub warts three or four times or more, and it will drive them away.

ASSOCIATION NEWS

THE SUPREME COURT DECISION ON THE CORPORATE RIGHTS OF THE AMERICAN MEDICAL ASSOCIATION.

In 1910 the state's attorney of Cook County (Chicago) was petitioned to institute "quo warranto" proceedings against the American Medical Association on the grounds that the Association's affairs were being conducted illegally in that its officers were elected at annual sessions held outside of the state of Illinois. The state's attorney refused to take action in the matter, and later, the attorney general of the state, who was appealed to, also refused to act. January 5, 1911, mandamus proceedings were begun in the circuit Court of Cook County, Illinois, to compel the state's attorney to initiate the quo warranto action which he had declined to institute. Until December 20, 1915, the issue was between the parties asking for the "mandamus" and the state's attorney of Cook County, Illinois; the point at issue being the technical one as to whether the state's attorney was compelled to act or had discretionary authority in the matter. The case went through the lower courts and finally was carried to the Supreme Court of Illinois, which in December, 1915, refused to hear arguments on the merits of the cause as it related to the American Medical Association, but ordered the Circuit Court to take up the original quo warranto proceedings designed to raise the question of whether or not Illinois corporations "not for profit" are compelled to hold their elections and conduct their business within the confines of the state. Up to this point the American Medical Association was not technically interested in the controversy; now, however, it became a party in the action. Quo warranto proceedings against the members of the Board of Trustees were instituted in the Circuit Court of Cook County, Illinois, which after trial rendered a decision favorable to the Association. The case was then carried to the Appellate Court of Illinois, which confirmed the decision of the Circuit Court. An appeal was finally made to the Supreme Court of Illinois, which last week (April 16) rendered its decision settling the question. This decision is entirely satisfactory so far as the Association is concerned. One paragraph of the opinion reads:

It seems reasonably to follow that if a corporation not organized for pecuniary profit may hold meetings at stated times outside of the State of Illinois, composed of delegates selected by the constituent associations, for the transaction of business of the corporation, it is not unlawful to authorize and provide for the election by said house of delegates of trustees of the corporation. The American Medical Association was organized solely for the purpose of the advancement of medical science. Its purpose was to improve methods for the treatment and prevention of diseases of the human race. Its usefulness for these purposes would be seriously interfered with, if not absolutely destroyed, if it could not provide for the election of trustees from the most efficient men in the association throughout the United States, by delegates selected by the constituent associations from the

various States in the Union. Such authority to the house of delegates is conferred by the by-laws and is not in conflict with or prohibited by the constitution or laws of Illinois relating to corporations not for pecuniary profit.

The decision is important not only to the American Medical Association, but also to all organizations incorporated under the laws of Illinois—in fact of any state —governing corporations "not for profit."

BOOK REVIEWS

Lessons From the Enemy. John R. McDill, M. D., F. A. C. S., Major. Medical Reserve Corps, U. S. Army. Cloth, illustrated, 260 pages. Price, $1.50. Lea & Febiger, publishers, Philadelphia and New York.

This is number five of the Lea and Febiger War Manuals. As it comes from the pen of a Wisconsin man whom we all love and admire it will be of special interest to the profession of this state. Information from the enemy and of the enemy has been almost impossible to obtain. Doctor McDill's long and enviable record in the Philippines for the Government made him one of the best men who could have been sent to Germany prior to the entrance of our country in the war. He was qualified to judge. He sailed for Germany early in 1916 as Director of a unit financed by a German, Austro-Hungarian Society of Chicago. The War ministry of Prussia gave him a special permit to study and inspect their sanitary system and get a clear conception of the medico-military and volunteer coördination and administration in the care of the sick and wounded. His work covers the German medical organization, administrative methods of the sanitary service, the Base Hospitals, Nursing, Welfare and Red Cross work, Reëducation of the Disabled, Orthopedic Hospitals and Workshops, Artificial Limbs, War Relief Work and Social Insurance and Hospital Systems in Peace. It is splendidly illustrated and will prove one of the most valuable contributions to medical war literature.

Long Heads and Round Heads, or What's the Matter With Germany. By Dr. W. S. Sadler of Chicago. 157 pages, illustrated. Cloth $1.00. Published by A. C. McClurg & Co.

Germany stands before the world a moral bankrupt. Why and how this happened is answered by Dr. Sadler through a study of Anthropology. The author traces the German people from prehistoric times and ends the work with twenty-five reasons why we must win the war. It is good reading and while we may not agree with all that he says, it "sets one thinking". It's worth while.

Burns and Their Treatment. By J. M. H. Macleod, M. A., M. D., F. R. C. B. 160 pages, illustrated. Cloth, $2.00. Published by the Oxford University Press.

The treatment of burns has undergone a veritable revolution during the past few years. The author's experience is based on his experience as Physician for Diseases of the Skin in Charing Cross Hospital and with the Royal Flying Corps Hospitals. Five chapters are given to Burns from Heat. He then takes up Burns from X-Rays, Radium, Sun, Corrosives and Dermatitis from High Explosives. The work is concise and to the point. It can be read in an evening and is well indexed for reference. A work of this character should be in every physician's library.

Syphilis and Public Health. By Edward B. Vedder, A. M., M. D., Lieutenant Colonel, Medical Corps, U. S. Army. Published with the permission of the Surgeon General by Lea & Febiger, Philadelphia and New York. Cloth, 315 pages. Price, $2.25.

The Author has made a careful study of the prevalance of syphilis in the United States. The amount found together with the inadequate treatment given has prompted the work on this book. Comparisons are made between the United States and other countries and between various classes. The sources of infection and methods of transmission are carefully covered. A chapter is given to personal prophylaxis and one to public health measures. An appendix covers laboratory methods, control in the army, and legislation that has been passed. The book is well written and is a valuable contribution to the literature on syphilis in its relation to public health and social service.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1917. Cloth. Price, postpaid, 50 cents. Pp. 169. Chicago. American Medical Association, 1918.

This volume contains the reports of the Council which were adopted and authorized for publication during 1917. It includes reports of the Council previously published in *The Journal of the American Medical Association* and also reports which, because of their highly technical character or of their lesser importance, were not published in *The Journal.*

In this volume the Council discusses the articles which were examined and found to be in conflict with the rules for admission to New and Nonofficial Remedies. Among these reports are discussions of such widely advertised proprietaries as Corpora Lutea (Soluble Extract), Wheeler's Tissue Phosphates, The Russell Emulsion and The Russell Prepared Green Bone, Trimethol, Eskay's Neuro Phosphates, K-Y Lubricating Jelly, Ziratol, Hepatico Tablets, Hemo-Therapin, Venosal, Surgodine and Kalak Water. A report on Iodeol and Iodagol covers 51 pages and illustrates the exhaustive investigation which the Council is often obliged to make of proprietary articles. Similarly illustrative of the Council's thoroughness is the clinical study of Biniodol, a solution of mercuric iodid in oil, and the investigation of Secretin-Beveridge, made for the Council by the physiologist, Professor Carlson, of the University of Chicago. The volume also contains reports which explain why certain preparations, such as Alcresta Ipecac tablets, the German-made biologic products and antistaphylococcus serum, which were described in the last edition of New and Nonofficial Remedies, are not contained in the current 1918 edition. Those who wish to be informed in regard to proprietary remedies should have both the annual Council Reports and New and Nonofficial Remedies.

Military Ophthalmic Surgery. Greenwood, Allen; de Schweinitz, Geo. E.. and Parker, Walter R., Medical War Manual No. 3. Authorized by the Secretary of War and under the Supervision of the Surgeon-General and the Council of National Defense. Lea & Febiger, Philadelphia and New York, 1917. $1.50.

Greenwood compiled this little handy volume from his recent personal experiences gained during two seasons with the Harvard Surgical Unit, British Expeditionary Force, General Hospital in France, and consulting in the surrounding Base Hospitals. It contains in condensed form suggestions helpful to medical officers who are confronted with special ophthalmic problems in the daily routine of active army medical work, especially in the dressing stations and hospitals throughout the war zone. First the contusions of the eyeball are discussed, then the wound of the eyeball, penetrating and perforating, traumatic cataract, penetrating wounds of the orbit, wounds of the eyelids, with treatment, prophylaxis, eye conditions that are an expression or diagnostic sign of disease or injuries elsewhere, psychoneuroses, refraction, with an appendix of indications for enucleation and evisceration. Operations, which will be required for later army and civilian construction work, e. g., plastics, have not been included.

The article by de Schweinitz on trachoma and infectious forms of conjunctivitis is an excellent exposé of this subject, considering the pathology, clinical appearance, differential diagnosis and treatment. Both articles are illustrated, the first by roentgenograms and the latter by colored plates.

The synopsis on the examination of malingerers by Parker will be found of great value to the officers conducting cantonment examinations. C. Z.

Materia Medica, Pharmacology, Therapeutics and Prescription Writing (Second Edition, Reset). Materia Medica, Pharmacology, Therapeutics and Prescription Writing. For Students and Practitioners. By Walter A. Bastedo, Ph. G., M. D., Assistant Professor of Clinical Medicine, Columbia University. Second Edition, Reset. Octavo of 654 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $4.00 net. W. B. Saunders Company, Philadelphia, London.

Pharmacology being one of the later sciences pertaining to medicine to receive the attention of students, is naturally, in its developing stage and accordingly is undergoing rather rapid, not to say bewildering, changes. A majority of the old time drugs are being relegated to the obsolete and discarded list; some of them are establishing themselves as appropriate and hopeful remedies based on the sure foundation of experimental observations, and others, some of them new and a few of them old, are demanding investigation and use.

The book under review has been before the public for several years and has been received favorably and this, the second edition, has been required in order to bring the text up to date.

This has been accomplished in an acceptable manner by rewriting some of the old articles and in the introduction of new matter on such substances as benzine, gasoline, benzol, kaolin, Fullers' earth, the Dakin-Carrel antiseptic treatment of wounds and a few others. The text is marred by a few rather loose sentences, and grammatical lapses, which however do not apparently convey materially erroneous ideas.

W. H. W.

A Clinical Manual of Mental Diseases. By Francis X. Dercum, M. D., Ph. D., Professor of Nervous and Mental Diseases, Jefferson Medical College, Philadelphia. Second Edition Revised. Octavo of 497 pages. W. B. Saunders Company, Philadelphia and London, 1917. Cloth, $3.50 net.

The average physician knows too little about mental diseases. He is apt to regard the whole subject as foreign to his province and strictly limited to the psychiatrist. As a matter of fact the practitioner is the very one who should have a knowledge of mental diseases, for he is the one who is first called in to see a patient who is acting strangely. To get this information to the physician has been a problem which has occupied the attention of alienists for some time. There have been a number of books written in the form of lecture courses. Such a one is Dr. Dercum's book. He has treated the subject with great clearness and has made a most readable text.

This second edition has been thoroughly revised and new material added. The general arrangement is the same as in the former edition.

Part I takes up the subjects of I. Delirium, Confusion, Stupor: II. Melancholia, Mania, Circular Insanity (Melancholia-mania, Manic-depressive insanity): III. The Heboid-paranoid Group (Dementia Praecox, Paranoia): IV. The Neurasthenic-neuropathic Disorders (Psychasthenia): V. The Dementias. Part II, is divided into chapters on The Clinical Forms of Mental Disease Related to the Somatic Affections, Mental Diseases as Related to Age, Mental Diseases Not Ordinarily Included Under Insanity, and Insanity by Contagion. Part III, The Psychologic Interpretation of the Symptoms, in which Freud's theories are discussed. Part IV. Treatment.

The Manual is a distinct contribution to the subject and can be highly recommended to the profession.

The Spleen and Anaemia Experimental and Clinical Studies, by Richard Mills Pearce, M. D., Sc. D., Professor of Medical Research, with the assistance of Edward Bell Krumbhaar, M. D., Ph. D., Assistant Professor of Research Medicine, and Charles Harrison Frazier, M. D., Sc. D., Professor of Clinical Surgery, University of Pennsylvania. 16 illustrations, color and black and white. J. B. Lippincott Company. Philadelphia and London. Price $5.00.

It is only within very recent years that the diseases of the spleen has assumed some sort of order out of the chaos of former days. Extirpation of the spleen empirically for several conditions associated with enlargement of that organ has stimulated experimental work.

The investigators at the Department of Research Medicine at the University of Pennsylvania have been foremost among those who have been actively studying the relationship of the spleen to blood formation and distinction, iron metabolism, cholesterinemia, etc.

The book before us is the sum of all the work to date. All of the material has appeared elsewhere in Journals. The great contribution of the authors is the collection into one volume of all the information scattered through the literature. In doing this they have rendered a great service.

The text is most interesting. The authors have gathered the gist of all the literature and with their own contributions have given us a book which is the last word on the subject for the present.

Dr. Pearce discusses the purely experimental side, Dr. Krumbhaar the clinical side, particularly the diseases of the spleen associated with enlargement, Dr. Frazier discusses the technique of the operation of splenectomy illustrated by a number of drawings.

No one who wishes to keep abreast of the important subject of diseases of the spleen can afford to be without this authoritative book.

BOOKS RECEIVED

A Manual of Clinical Diagnosis by Means of Laboratory Methods for Students, Hospital Physicians and Practitioners. By Charles E. Simon, B. A., M. D., Professor of Clinical Pathology and Physiological Chemistry in the University of Maryland Medical School and the College of Physicians and Surgeons, Baltimore, Maryland. Ninth edition, enlarged and thoroughly revised. Illustrated with 207 engravings and 28 plates. Lea & Febiger, Philadelphia and New York. 1918. Price, $6.00.

American Addresses. By Sir Berkeley Moyhnihan, M. S., F. R. C. S., Philadelphia and London. W. B. Saunders Company, 1917. Price, Cloth, $1.75 net.

Clinical Lectures on Infant Feeding. Boston methods, by Lewis Webb Hill, M. D. Junior Assistant Visiting Physician, Children's Hospital, Boston; Alumni Assistant in Pediatrics, Harvard Medical School. Chicago method, by Jesse Robert Gerstley, M. D., Instructor in Pediatrics, Northwestern University Medical School, Associate Attending Pediatrician, Michael Reese Hospital, Chicago. W. B. Saunders Company, Philadelphia and London, 1917. Price, Cloth, $2.75 net.

Materia Medica: Pharmacology: Therapeutics Prescription Writing for students and practitioners, by Walter A. Bastedo, Ph. G., M. D., Assistant Professor of Clinical Medicine, Columbia University; Associate Attending Physician, St. Luke's Hospital, New York; Attending Physician, City Hospital, New York; Consulting Physician, St. Vincent's Hospital, Staten Island; Consulting Gastro-enterologist, Staten Island Hospital; Fifth Vice-President, United States Pharmacopoeial Convention; formerly Curator of the New York Botanical Garden. Second edition reset. W. B. Saunders Company, Philadelphia and London, 1918. Price, Cloth, $4.00 net.

The Third Great Plague. A discussion of Syphillis for everyday people, by John H. Stokes, A. B., M. D. Chief of the Section of Dermatology and Syphilology, the Mayo Clinic, Rochester, Minnesota; Assistant Professor of Medicine, the Mayo Foundation Graduate School of the University of Minnesota. W. B. Saunders Company, Philadelphia and London. 1917. Price, Cloth, $1.50 net.

Infant Feeding. By Clifford G. Grulee, A. M., M. D. Assistant Professor of Pediatrics at Rush Medical College (in affiliation with the University of Chicago); Attending Pediatrican to Presbyterian Hospital and to the Home of Destitute Crippled Children, Chicago. Illustrated. Third edition, thoroughly revised. W. B. Saunders Company, Philadelphia and London. 1917. Price, Cloth, $3.25 net.

New and Nonofficial Remedies, 1918, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1918. Cloth. Price, postpaid, $1. Pp. 452 + 26. Chicago. American Medical Association, 1918.

This annual should be in the office of every physician. It lists and describes all those proprietary remedies which the Council on Pharmacy and Chemistry has examined and found worthy of the confidence of the medical profession; that is, articles the composition of which is disclosed, which are exploited truthfully and which give promise of some probable therapeutic value. The description of each article aims to furnish a statement of its therapeutic value and uses, its dosage and method of administration as well as tests for the determination of its identity and quality. Articles of similar composition are grouped together and in most cases each group is accompanied by a general article which compares the members of a group with each other and with the established drugs which they are intended to replace. The description of the individual articles and the general discussions are written by experts and furnish information of a trustworthiness unsurpassed by any other publication. The book is especially valuable to the busy physician who desires a concise and up-to-date discussion of such subjects as digitalis therapy, the newer solutions for wound sterilizations, iron therapy, food for diabetics, the value of sour milk therapy and of the bulgarian bacillus, the use of radium externally and internally, of arsphenamine (salvarsan, arsenobenzol, diarsenol) and neoarsphenamine (neosalvarsan, neodiarsenol), of local anesthetics, and other advances in therapeutics.

In addition to this annual issue of the book, supplements are sent from time to time to purchasers. With this volume for ready reference, the physician will be able to determine which of the proprietary remedies that are brought to his notice deserve serious consideration. At least he will be justified to subject to close scrutiny those which have not met the requirements for acceptance of New and Nonofficial Remedies.

The book is sent, postpaid, for one dollar. Address the American Medical Association, 535 North Dearborn Street, Chicago.

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ORIGINAL ARTICLES

ADDRESS OF THE PRESIDENT, WISCONSIN SURGICAL ASSOCIATION, Milwaukee, 1918.

BY HORACE MANCHESTER BROWN, M. D., MILWAUKEE.

I am very much astonished, indeed, to see so many men present here to-night. In going over the list of members of the organization I found about thirty-five per cent of the members of this Association are in actual service, or are awaiting orders from the Government. Of the balance of members, there are sixteen per cent engaged in Advisory Board or Local Board work, which makes it quite impossible for them to get away to come to a meeting of this kind. So you can readily see that the smallness of our gathering to-night is no index whatsoever of the prosperity of the organization.

Financially the organization is in the very best possible condition, and the question of getting together a number of men in Milwaukee from out in the state this year was only one, I believe, which depended for its numbers upon the number of men who were free from Government service.

At the meeting of the Board of Regents, when the question of the arrangement for this meeting was brought up, your President was authorized to communicate with some distinguished and well known member of the profession outside of the city, to ask that such a man should come here to give us the benefit of his experience in a paper or an address of some kind; and your President wrote to twenty-three different men, all of whom, or any one of whom, it would have been a pleasure and an honor to have heard. Twenty-two of the men are in the Government service, and the twenty-third man, Rylus Eastman of Indianapolis, is sick abed and could not come. So you see the difficulty under which your Board of Regents and your President have labored in endeavoring to get up any sort of a program for the Society outside of the immediate membership.

Beside that, another factor limiting the number of men who would have been present from the state is that the men out in the state are busy, overbusy, not only with Government work in the various advisory and local boards for examining registrants, but taking care of practice that cannot be looked after by men who have gone into the public service—gone into the Army from these districts. Therefore I think, instead of being at all discouraged at the small number of men we have present to-night, we ought to feel rather proud to think that so many men have been able to get away to attend the meeting.

I shall not bore you very long with my "President's address."

It is the custom in every scientific society that, at the time of his assumption of the office of President—an assumption which is in most instances at a time when he is very near the hour of his abdication—for that officer to deliver an address, and it is often an opportunity for him to bring before the body over which he presides a resumé of the progress that has been made in the science that the society represents, during the year that has passed. It is not my intention to take advantage of my opportunity to talk to you to do anything of the kind; but rather to refer largely to a number of things that it seemed to me were of importance in a practical way, both for the advantage of the individuals composing this organization and possibly to the advantage of the society itself. Therefore, with a short reference to one of the founders of this society, I shall plunge into the midst of the things that it has seemed to me to be of moment to us at the present time.

It becomes my sad duty to call your attention to the loss which this organization has sustained in the death of Dr. Levings. As you all know, Dr. Levings was an aggressive man in the brotherhood of surgeons; a man with rare personality, and an impressive manner. A man whose capacity for

making friends was only to be compared to his ability for enthusiastic work at anything to which he put his hand and heart. His career as a surgeon was one of continuous labor and self sacrifice for the accomplishment of the things that he held dear, both socially and within the ideas that he conceived were for the advancement of the profession that he ornamented.

He was a good friend to his students, and their enthusiasm for him while living, and their pronounced sorrow at the event of his death, are a worthy and fitting testimonial to his character. I suggest that a committee be appointed for the purpose of drawing up a testimonial upon his demise, and that such a letter of sympathy, in the name of the society, be conveyed to his family.

At the present moment the surgeons of the country are facing a problem that is of the largest importance to them individually, and it is a problem that must be met with courage, and with a spirit of self sacrifice. In neither of these attributes has the profession of medicine ever been found wanting. The Surgeon General has called for volunteers for the Medical Department of the army, to the number of 5,000 surgeons. I understand that the number allotted to this state is in the neighborhood of 200 men. Already there has been an enthusiastic response to the previous call, and many hundred of the best and bravest of the medical profession of the state have answered it, and are—some of them—already in the trenches and on the firing line in France. Wisconsin has no reason to be ashamed of the response of her physicians to that call. But she must make a further effort and give more of her men, freely, willingly, and without asking questions. That she will do so is not for a moment to be doubted. The career of surgeon in this war is one that is most enviable, and there are at this moment sitting here many men whose age is the only disqualification and hindrance to their immediate acceptance of that duty. When this war is over there will be but two kinds of men in the world, those who were in the war and those who were not. And I feel sure that the former class will be the envy of those whose physical disabilities or age have kept them from the perilous adventure. It becomes our duty, as members of this Society, to make every effort for the furtherance of the demand of our country upon the personnel of our profession. I am sure the call will not go unanswered.

It is to be remembered that the present war has placed a new and nobler status upon the regular profession. The country seeks no additions to its medical corps, drawn from the ranks of the multitude of medical, or religio-medical sects. It looks only for the best, and expects to find, and will find, that "best" only among the medical men trained in no special school of practice, in no hide-bound "pathy" or "practics". The Government recognizes that science is ever ready and eager to change its views of life and nature, so soon as exactitude and investigation have shown that there is a better way than the old by which to provide protection from disease, or if disease be already present, to provide rational and proven methods of treatment of that disease.

But we, as well as all other members of the healing art, must not slumber in contentment with that fact. Already there are plans afoot, the produce of the dishonest and designing brains of the protagonists of a number of the "pathies" and "practics", to obtain recognition and military office within the medical corps of the army and navy. Our politicians are all too often the too ready acceptors of the belief in "cures". Their ignorance of all things medical making them the too ready believers in the logic of "post hoc, ergo propter hoc", and—well—you all know the insatiable appetite of the office holder for votes. Between that appetite and ignorance some of these plausible faddists may find a way to usurp the right to help in maintaining our soldiers in health that belongs only to the men whose education is along the path of established knowledge, not acquired in the noisy halls of quackery, impudence, and unproven assertion. Let no opportunity to oppose and obstruct any such movement on the part of the gang of insidious liars and mountebanks escape you. Recognized as we are by the government, and by the commonsense of sensible people, we should put a new and higher value upon ourselves and upon our common profession, and should not fear boldly to attack any scheme that has for its object the introduction of any of the fads and "isms" into the Medical Department of our forces. The soldier and the sailor are entitled to the best—the very best—and it is one of our duties as well as privileges to strive to educate those about us in the need that that best be given him, and given him by medical men whose scientific attainments are above question.

It seems to me that this unqualified recognition of the value of our profession by our country should teach us a lesson. A lesson at one time in the history of medicine that was well learned, but alas for now many years forgotten, and that lesson is that we should place a greater value upon ourselves. The standing of the medical profession in the eyes of the business world has sunk lower and lower; in the eyes of the governing body of our states and cities it has reached almost to the dregs of the social cup; in the eyes of the makers of laws it makes but little, if any, impression, and in the eyes of the business world we stand as a convenient sort of tool that is to be used for the advantage of the business man as and when he sees fit, to be cast aside without recognition when he has no more immediate use for it.

The Legislator is continually getting up schemes for what he calls the "betterment of the laboring man", but which are but plans for getting votes and by means of which he may pose as a benefactor, and in most of these schemes the doctor, and especially the surgeon, is the goat, and, like most goats, he gets but a thistle for his reward, and often not that for his proud caprigenous position. On every hand and with the sitting of every legislature there are new schemes brought forward by the makers of laws, to carry forward some sort of plan like the Workman's Compensation Act, the law for Compulsory Health Insurance, or some other of that ilk, and always underneath these plans there is an opportunity for the makers of the laws to use and abuse the short-sighted and unsuspecting doctor for his own ends. And so foolish is the doctor that he seldom if ever sees through the game of the sly legislating bunko-man.

And there is no reason why the business man, the law makers and the insurance men should not use us about as they please for their advantage, for have we not as a body continually cast our pearls before swine?

In our efforts to obey the most cherished precept of our ethics—that which bids us to be of service to the poor and unfortunate—have we not been coerced by the business man, the law makers, and insurance men into numberless acts of business folly, believing ourselves to be giving to the poor of the plentitude of our abilities, when, in fact, in the last analysis, we have been simply the victims of schemes for the betterment of the pocketbook of the business man, the law makers, and the insurance men. We have indeed cast our pearls before swine, and they are the swine.

How does the Workman's Compensation Act work out as far as it relates to the medical men?

The employer takes out insurance in an insurance company that he may be protected against damages for injuries received by his employees. The insurance company does not wish to pay these damages, although it is very glad to receive the premiums; it therefore hires a lawyer, and very often a pretty bum one at that, to defend it against the claims of the employee. The lawyer does not desire as a rule that the physician employed to care for the employees by the insurance company be a man of standing, either professionally or ethically, and what is the result in the end as far as the injured man is concerned? His employer shifts him onto the insurance company, the insurance company employes a poor surgeon to care for him, and a lawyer of doubtful standing to assist it in avoiding the payment of the indemnity. If the employer chooses his own physician and that physician is one who demands proper remuneration for his services, the insurance company quickly interferes in favor of its own cheap medical employee, and both the doctor and the injured man are suspended between the devil and the deep blue sea.

That is absolutely true. I can bring you eight cases where respectable and established medical men have been literally kicked out of their places through the activity of the insurance companies insuring employers against indemnity to their employees, on account of the activity of the lawyer that represented the insurance company.

Now, how about the insurance companies and the doctor? You are all of you familiar with the demands made by the casualty companies upon medical men who have cared for the clients of the companies who have received injuries, demanding that the medical men should spend their time, money, postage, stationery, office rent, expense and knowledge in making out reports for the insurance companies in case of claim by an injured person, for nothing.

There never was a greater or more silly imposition placed upon our profession than this one, to which we have almost universally submitted for so many years. Is it not time that we as a body ceased to be the unpaid detectives and clerks for the insurance companies and demanded of them a proper and reasonable fee for every form of report

that we make for them. We lose nothing by making this demand, and in most instances if we refuse to make out the records and demand a fee for doing so, the insurance companies will come to us with their hands stretched out, ready and anxious to pay for the service which is so important to them and which we alone can render. A million dollars each year might be and should be collected by the combined medical profession of the United States as remuneration for the service above mentioned.

There is another cloud hanging in the horizon which threatens with its growth to deluge our profession with a new and I believe almost insuperable calamity, and that cloud is the new compulsory Health Insurance movement.

This is not a time to go into the particularities of this movement, but it is safe to say that the whole thing is but an attempt on the part of well meaning but shortsighted and mistaken philanthropists to force another one of their fads upon a public that neither desires nor seeks any such change in its personal acts. Man is no different from any other animal, in the matter of his attitude toward himself and the benefits that he may derive from his surroundings. Like all other bodies animate or inanimate, he moves in the direction of least resistance, and so long as a misguided and mistaken philanthropy furnishes "games and bread" for his nourishment and amusement, and these gratis, he will make no effort to secure them for himself. But in the matter of his personal health and that of his family he can find his benefit only through the activities of our profession and so soon as that profession submits to dictation from politicians, philanthropists, and all other queer forms of fish, it starts on the downward road that leads to diminishment of public respect and abasement of personal initiative to personal improvement.

The committee of the American Medical Association having charge of the investigation of the matter of this movement for compulsory public health insurance has warned us that the time has not yet come for the acceptance in this country of such a social movement.

I beg every member of this society to look carefully into the matter before joining his suffrage to that of short-sighted people for the advancement of this un-American fad.

In our profession we have let a great many opportunities for self protection and for social and business activity for our protection slip past, because either we have been afraid of losing friends, or afraid to speak our minds, afraid to oppose the sentiments and the sympathies of the large number of people who do very little thinking, a great deal of talking, and a whole lot of feeling. We have permitted to grow up among us two or three medical fads, medico-religious hallucinations, that have in a very great degree injured us not only in the eyes of the general public, but injured us in our pockets. It is the fairest thing in the world that we should go out to Madison and have a law made to limit the activities of the osteopath, the chiropractic, and the naphropathic, whoever they are, or the Christian Scientists. It is perfectly fair that if men and women, under any possible excuse whatsoever, or under the action of any possible philosophy, ism or asm, wish to treat disease, that they should be called upon to spend as many years in the study of the fundamentals of medicine: anatomy, physiology, etc., as we who have had to pay for our lessons and experience and who have had to pass examinations by a Board of Examiners before we were permitted to do so. But as it stands today, we spend from five to nine years of our lives in studying medicine, during a very substantial part of which time we receive no return whatsoever. We spend, if we count our time as of any value, in the neighborhood of twelve at the very lowest, and more likely fifteen thousand dollars in acquiring our education; and we are placed by our makers of laws in the position where we have to compete in our business life with individuals who acquire their diplomas in a three weeks course in a chiropractic school, a one month course in an osteopathic school, and I don't know whether the naphropathics spend more than twenty minutes or half an hour in acquiring their credentials or not.

It is reasonable that we should sit still and not force it upon our law makers to see to it that men following these fads in the treatment of disease should be obliged to put in at least as much time and study as we do before they are permitted to wreak their theories and isms upon an unsuspecting public? And now about Christian Science: Of course, the moment you tack the word "Christian" onto anything, your hands are tied. You have to put them right behind your back, hold your head down and never say a word, and never look

sideways, for fear you may hurt a religion. There is just as much religion in Christian Science as there is hair in the palm of my hand. It is neither religion nor anything else. It is a resuscitation for about the fiftieth time in the history of mankind of the same old admission of Xenophantes that he didn't know anything, and that he didn't even know that he didn't know anything. In other words, it is the idea of Pytharagoras preached some seven hundred and ninety years before the birth of Christ. Anyone who will read the precepts of Pytharagoras will see the whole philosophy that was preached by Dr. Quimby, and which was taken up by Mary Baker Eddy, in regard to the effect of mind upon matter. It is absolutely absurd from beginning to end—an entirely disrupted and destroyed philosophy long years before Descartes wrote his famous "Discourse on the Method" in the Seventeenth Century. And you all know what liars they are. They make their own diagnosis and then cure themselves of the diseases that they imagine they have.

The idea is that Mary Baker Eddy sits on the right hand of God, and every morning about nine o'clock she touches him (illustrates) and says: "God, Mrs. Jones' bowels have not moved this morning. Attend to it, please, will you? She is reading a book for which she paid $2.75." And then God shifts his vision from the Universe and looks after Mrs. Jones' bowels. That is all there is to it. If there were any sense in it, any logic whatsoever, instead of having trench fever, gas gangrene, or any of the rest of the things that go with this horrible war, all that would be required would be for some able, busy and strenuous "Reader" to spend a quarter of an hour reading Mrs. Mary Baker Eddy's book, to remind her to punch God on the shoulder and tell him to stop all this thing, and it would be stopped instantly. So we can very well let them grind out their own damnation. It may take another generation, but it is sure to come.

There is another problem that this Society may very well take up: Could something be done of a practical nature by a Society of this kind, representing as it does the surgical element of the state of Wisconsin, in furthering—or, in starting and carrying through—what has been attempted a number of different times in different parts of the United States; and that is the establishment of a series of Standards of time, or standards that will relate to the question of time that a man is disabled after receiving a certain class of injuries, before he could be declared able to return to work.

Perhaps no problem that comes before the man doing general surgery—and there are men doing, what do I want to say—industrial surgery—no problem that is more difficult to decide than the problem of time required, say, following a fracture of the os calcis, following a fracture of the astragalus, or following fractures near the extremities of any of the long bones, fractures in the neighborhood of joints, whether the joint is involved or the joint is not involved; that is, the amount of time that can be justly considered, all circumstances being taken into consideration, that shall elapse from the time of receiving the injury by the individual until the injured party shall be declared able to take up his work again. We have to do it mostly by guess work. There have been a few attempts at development of standard tables for such conditions, but nothing that I know of that is in any wise satisfactory; and it might be that such an effort could be initiated with us, and if we have the means and the facilities the effort could be extended into other states and some sort of a table, which would necessarily be only approximate, might be formulated which would give us a basis for an estimate.

Ordinarily we think, for instance, that a fracture of the os calcis is a matter of a few months. It is not. It is a matter of a year or a year and a half, and very often two years before a man with a fracture of the os calcis, involving the ankle joint, is in condition to go to work, and do such work as he did before the injury, and all the efforts you make with all the different apparatus you may try, will not modify that time in the least. The same thing has to deal with matters of resection of joints and things of that kind. Would it be possible, after this paper has been read, if you choose to discuss my address at all, to formulate an idea for a committee of the Society to investigate such a matter and report at the next meeting?

And then another very delicate subject: Is it worth while for us, in the present condition of affairs in the country, to attempt to agitate toward in some way limiting what I believe to be the enormous amount of unnecessary operating that is being done? I will say nothing on that subject, but think about it.

At the very beginning of the organization of this Society, the question arose, and it has many times been repeated—nor is the question one that is without good reason for its asking: "Is there any need for a State Surgical Society?" Within the past year a number of men who are members of the Society have come to me with the same question. It has been advanced that under the new form of organization of the State Medical Society, the division of the latter into its three sections had provided a way by which the men of that society whose path leads them more distinctly along the road of surgery, might so adjust the activities of the surgical section of the State Medical Society that there might be greater activity of that section during the passing of the year between the annual meetings of the State Medical; that tri-monthly clinical meetings of the surgical section might be arranged for, to be held at different points within the state, and that by means of such meetings, the standard of surgical practice among the surgeons of the state might be elevated, more harmonized and standardized. Then the members of the State Surgical Society might be spared the payment of another fee for dues, and, in short, that a separate society for the surgeons was neither desirable nor necessary. At times I have been prone to take that view of the matter myself, but again it has seemed to me that there is a field for a Surgical Society within the state, and that it requires but a trifle more enthusiasm among the members of the existing organization to make that seeming a reality. But these are perilous times. At the present time the conditions among the men of the surgical side of the profession are not such as to justify any of us in taking sides for either view. It would seem advisable that whatever may be the final outcome of the situation as between the Surgical section of the State Medical Society and the State Surgical, conditions should remain as they are until after the great war is over and the relations of the Medical profession to the public and of its individual members to the Societies can have a chance for sedimentation. There was, no doubt, at one time a condition of affairs in London when there was doubt as to the justification for the existence of the Royal College of Physicians and the Royal College of Surgeons. London grew. The population of the state of Wisconsin is growing, and I believe we should look well into the future before we abandon the effort that we are making, even in our feeble way, to establish our right to existence through our efforts toward mutual improvement and individual betterment, by way of the organization which is now so well established. Let us then continue as we are, making each year a renewed effort to make a name, and a place for ourselves, until, unless some unfortunate castastrophy should befall us, we have justified our existence before the entire profession of the state. Yes! Before the profession of the entire country.

Such an end will be the result only of the individual strivings of our members, and the aggregate of their efforts to sustain our organization will be the testimony that we must lay before the profession and public, a testimony that must be of such convincing nature that there may be no question of the justification of our faith in ourselves and our society. It is for the individuals of the society to decide, through their co-operation and enthusiasm, whether we are entitled to the right to live or not.

DIABETES MELLITUS.*

BY H. H. MILBEE, M. D.,

MARSHFIELD, WIS.

Mr. President, Ladies and Gentlemen:

Diabetes was known to the Egyptians long before the time of Moses as a disease characterized by polyuria. The Greeks and Romans also observed the disease and laid great stress upon the polyuria and thirst. It took, however, hundreds of years before Willis in 1679 discovered that the urine was sweet and another hundred years before Dobson of Liverpool demonstrated that this sweetness was due to the presence of sugar. From this time on, diabetes millitus was slowly separated from diabetes insipidus.

There have been many definitions of diabetes mellitus, all of which are more or less unsatisfactory. Probably one of the best definitions would be to say that diabetes mellitus is a disease in which the normal utilization of carbohydrates is interfered with and as a result of which glucose appears in the urine. According to the most modern idea, it is probably best for the practi-

*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, 1917.

tioner to consider diabetes to be a disease in which this normal utilization of carbohydrates is impaired because of the weakness of a bodily function, primarily the function of the pancreas. At the present time, it is safe to consider a patient with diabetes mellitus as a healthy individual with the exception that he is unable to tolerate the amount of carbohydrates or carbohydrates, proteins and fats which a normal person ought to be able to do.

Normally, the carbohydrates are changed into glucose in the alimentary canal. They are then absorbed by the radicals of the portal vein and carried by the blood to the liver. The liver, in turn converts the glucose into glycogen and stores it up as such. Removal of the sugar from the blood is so perfect that even after the injection of a large amount of carbohydrates, the total blood sugar is but slightly raised. To meet the body needs, the liver retransforms this glycogen into glucose and sends it out into the blood stream. This double transformation is performed by special hepatic ferments. Hence, we see that it is the liver which maintains the percentage of blood sugar at almost a constant level. The liver is assisted in this, to a small degree, by the storage of glycogen in the muscles and by the formation of fat from glucose. For practical purposes, we need not consider these other agencies in the maintenance of the normal blood sugar which usually remains in the neighborhood of .09%. It is not the purpose of this paper to discuss the various other forms of glycosuria such as those occurring in diseases of the hypophysis, after the injection of epinephrim or phlorhizin, those associated with various lesions of the nervous system or the so-called renal glycosuria. It is also doubtful whether there is any relationship worth while considering between alimentary glycosuria and diabetes mellitus. While we know that some patients with alimentary glycosuria do become true diabetics, we also know that a great majority of them never do and that many people who have never shown an alimentary glycosuria do develop diabetes mellitus.

In diabetes mellitus then, we have a disturbance in the normal bodily function which maintains a blood sugar percentage that varies but slightly. We have the presence of sugar in the urine continuously, disturbances of carbohydrate and fat metabolism, together with various nutritional changes in the tissues. It seems most probable that the body has lost, to a greater or less degree, the power to burn glucose even though present in the blood in excessive quantities. This is the one great difference between diabetes mellitus and all the other forms of glycosuria. We may, however, state that many observers do not believe that it is a specific disturbance of sugar combustion. They would rather consider diabetes as a syndrome in which we have a chronic disturbance characterized by the appearance of glucose in the urine and that this sugar in the urine depends upon the fact that we have a hyperglycaemia present.

It has been shown that the pancreas, kidneys, central nervous system, chromaffin system, liver, thyroid and hypophisis are all diabetogenous organs and may play some part in the development of diabetes. For practical purposes, however, it is best for all ordinary clinicians to consider diabetes as a pancreatic disease, forgetting the other organs which may have some small bearing upon the production of this condition. Allen has shown that a very definite relationship exists between the severity of the glycosuria and the amount of pancreatic tissue removed from the body. The diabetes thus produced by the removal of pancreatic tissue is apparently due to the lack of some effect which the pancreas normally exerts upon the chemical processes of the body.

Regarding the lesions in the pancreas, there are those who hold that it is the glandular parenchyma that is most involved, others hold that it is in the islands of Langerhans' where the distinctive lesions occur, while still others hold that it is both parenchyma and islands that are involved. There have been severe cases of diabetes reported by competent observers where no lesion of the pancreas could be demonstrated. These cases force us to admit that we may have a markedly diminished carbohydrate function of the pancreas without any demonstrable lesion or else that the lesion is located in some other organ as the central nervous system or the hypophysis. This has led Allen to conclude that nervous factors may play an important part in the production of diabetes in dogs predisposed to this disease by partial pancreatectomy, or in patients predisposed by some unknown pancreatic change.

In diabetes, we find the whole process of normal metabolism altered. The glucose is no longer formed from the carbohydrates alone, but is also produced from the amido-acids which are split from the protein molecule as well as from the gly-

cerine derived from the fats. This abnormal production of glucose occurs in the liver. We further know that the liver and muscles, in all but the mildest cases of diabetes, no longer store up glycogen. It has been shown also that in the carbohydrate metabolism of diabetes, some carbohydrates are much better tolerated than others. This led VonNoorden to the establishment of his oatmeal treatment because of the fact that in certain diabetics, the oatmeal is well handled. In considering the Protein Metabolism, we find the high nitrogenous output is probably due to the increased protein intake. In cases with marked emaciation, the nitrogenous output is increased by the breaking down of the proteins of the body musculature. The degration of the proteins in diabetes closely follows the normal paths. The fact that part of the nitrogen appears in the urine as ammonia instead of urea, in cases with acidosis, is due to the union of the ammonia with organic acids and this prevents its further synthesis into urea.

It is from the metabolism of the fats that we get the formation of those dangerous acid bodies, namely acetone, beta-oxybutyric and diacetic acids. It is these acetone bodies which produce the dreaded symptoms in diabetes and its frequent termination coma. They appear to be formed in the liver and it is their accumulation which produces the so-called acidosis. They are formed in normal metabolism but do not accumulate in the body as long as the carbohydrates are split and oxidized in the proper manner. Even when the body is only capable of utilizing forty grams of glucose, there is very little accumulation of the acetone bodies and no ketonuria, i. e., their appearance in the urine. In absolute starvation, acidosis appears rapidly because the body glycogen is soon consumed. This acidosis can be prevented by the giving of one hundred grams of carbohydrates per day. This occurs even though we know that the hundred grams of carbohydrates is not sufficient to keep up the body nutrition. Hence we see that acidosis and ketonuria not only depend upon an insufficient body nutrition, but also upon an insufficient supply of carbohydrates. If you give a sufficient quantity of protein and fats, but no carbohydrates, you get the formation of the acetone bodies the same as in complete starvation. The giving of large amounts of meat tends to prohibit the formation of the acidosis because the proteins give rise to the formation of the glucose or other bodies with inhibiting action. If the carbohydrates are kept excluded, the acetone bodies tend to diminish or may even disappear because the body seems to be able to adjust itself to a protein-fat diet. In diabetes, we get the acidosis because the body cells are unable to utilize the excessive glucose in the blood. Allen has proven that complete starvation of patients with diabetes tends to reduce the acidosis. We do not know the reason for this but it appears that by starvation, there is an improvement in the patient's ability to handle carbohydrates as well as his ability to burn the ketone bodies.

It is now known that the presence of acetone in the urine is not of much importance and that it comes from the decomposition of the diacetic and beta-oxybutyric acids. The beta-oxybutyric acid is the real toxic agent and it usually forms from 60 to 80% of the total acetone bodies.

In estimating the amount of acidosis in our patients, we depend wholly upon the qualitative tests for acetone and diacetic acid, together with quantitative estimation of ammonia. These apply to the urine. We also add to this the determination of the carbondioxide tension of the alveolar air as recommended by Marriott. The estimation of the ammonia is made with Folin's apparatus and it is an excellent guide to the amount of acidosis as it measures the reaction of the body in its endeavor to counteract the acid state. It must be remembered, however, that the estimation of ammonia is of no value when alkalies are administered. Normally, the ammonio-nitrogen ratio should be about 4%, but in diabetes with acidosis, this is markedly increased. For technical reasons, we do not estimate quantitatively the acetone or diacetic acid or test for beta-oxybutyric acid.

With the brief review of some of the important facts concerning diabetes mellitus, we may well approach its modern treatment. It is now an established fact that drugs play but a small part in the treatment of this disease and it is our opinion that the method advocated by Allen is the most logical and best plan to follow. The following is a brief synopsis of his treatment as practiced by us.

We first require our patients to enter the hospital as we believe it is to their advantage to be where they can be under constant observation, where the diet can be accurately estimated, and where the laboratory facilities are adequate. They are put to bed and for two days receive the regular

hospital diet. During this time, the amount of sugar and acidosis is accurately measured and a general survey of the severity of the case and condition of the patient is estimated. Starvation is then begun and we allow the patient only water, coffee, tea and broth during the daylight hours. This is continued until he has become sugar free for a period of forty-eight hours. If the case shows signs of weakness or should we suspect that coma might intervene, alcohol is administered. After being sugar free for two days, we gradually commence feeding. It has been our experience that while the glycosuria usually disappears quite rapidly, the acidosis in a lessened degree persists after the disappearance of the sugar for some days to come. The first fast period usually lasts from two to ten days, but all subsequent fast periods need only be for a single day. The feeding is gradually increased, watching all the time for the reappearance of glycosuria or an increase in the acidosis. The appearance of even a trace of sugar must be followed by a fast day either with or without the use of alcohol. During this period, the protein carbohydrates and fat intake as well as the bulk of the food must be carefully estimated. A certain bulk to the diet is necessary to prevent constipation and satisfy the patient. For this reason, the green vegetables are used and may be taken raw or boiled. When boiled, the water should be evaporated to leave the carbohydrates and salts in the vegetables. This is the method used for the preparation of the vegetables in all the mild cases, but in the severer ones, they cannot be prepared in this way, nor can they be given raw as they will cause a glycosuria to rapidly appear. Here we must boil the vegetables at least three times, each time throwing the water away. This removes nearly all the carbohydrates present and can be given without causing the excretion of sugar.

In estimating the carbohydrate tolerance, the five per cent vegetables are usually given and the amount daily increased until a trace of sugar appears. A fast day is then prescribed and the number of grams of carbohydrates given, previous to the appearance of the sugar, is the point of tolerance in the individual case. The protein tolerance is then determined in a similar manner by increasing the amount daily until a trace of sugar appears. When we have the carbohydrate and protein tolerance, we then start the fats and increase them 5 to 25 grams daily, until the patient ceases to lose weight. We may increase the fat faster, but we must be governed by the amount of acidosis the patient had before starvation. When we have ascertained the food tolerance of our diabetic patients, they must henceforth live upon food which is safely below the point of their carbohydrate, protein and fat tolerance. Patients upon this treatment, usually lose weight but in the majority of cases, this is beneficial. The intake of proteins should usually be kept low and in the severest forms of this disease, all classes of food must be greatly restricted. When the protein tolerance is very low, it may be necessary from time to time to exclude carbohydrates for a short period and then allow as much protein as possible without causing a glycosuria. In all cases where the carbohydrate tolerance is very much lowered, it is necessary for the patient to observe one fast day each week. If the carbohydrate tolerance is only moderately lessened, this fast day may be dispensed with, but in its place the regular diet for the day should be simply cut in half.

In concluding this paper, we believe that the Allen method of treatment for diabetic patients is the best method yet devised. We know that in some cases it does not appear to work satisfactorily, yet we believe that the greater percentage of cases are apparently cured as long as they remain faithful to their diet instruction after having been rendered sugar free and a careful estimate of their point of tolerance has been made. There is so much to be said upon diabetes mellitus that the only excuse we have to give for offering this paper is that it may bring forth an abundance of discussion which will be of mutual benefit to us all.

DISCUSSION.

Dr. H. P. Greeley, Madison: Mr. Chairman and Gentlemen of the medical profession. I think this paper is of interest to every practicing physician, for two reasons: Diabetes has been very much in the limelight for the past two or three years, and deservedly so, because our standards of practice in regard to the treatment of that disease have changed very much in a very short time. It is a chronic disease for which, I think, more can be done than is the case with almost any other chronic disease, and at the same time it is a chronic disease that is ordinarily treated in a worse manner than any other chronic disease, and that is not any aspersion on the general practitioner of medicine, but is due to the fact that the standards of treatment have changed very recently. Whereas a few years ago most of the physicians were

attempting to treat their patients and reduce the output of sugar, avoiding, if they could, any danger of acidosis, now our standards are nothing short of the complete elimination of sugar, permanently, if that is a possible thing. We have come to this standard of practice by very gradual stages. It has been an evolution which has been very interesting to watch. The first thing that was done in the treatment of diabetes was the restriction of carbohydrates. That treatment very seldom resulted in any great benefit to the patient, except in mild cases. It often resulted in very great harm to the patient, because the mere restriction of carbohydrates frequently resulted in a very rapid increase in acidosis. Then it was Naunyn who emphasized the fact that the protein must be restricted as well as the carbohydrates, in order to get better results. And much better results were obtained under this method of treatment than under the method of pure carbohydrate restriction. But even then our results were not of any great advantage to the patient, except in mild cases. So that we have now come to the standard of treatment in which we must restrict the carbohydrates, and the protein, and also restrict the fat. We might call it calorie feeding: that is to say, we feed a person according to his actual needs, and not according to any theories of diabetes. For instance, the person is an engine and can burn a certain amount of food each day, and needs a certain amount of energy to do his work each day, and the science of nutrition and study of metabolism have shown us exactly what his needs are, and those needs are calculated upon the basis of his weight, his surface area, his age, and the work that he is called upon to perform each day.

Now in treating diabetes we cannot always treat the individual as he is. I think it is sometimes better to treat the individual as he should be. By that I mean that a person having diabetes and weighing 200 or 225 pounds had better be treated on the basis of what he should weigh rather than on the basis of his actual weight. He would not have gotten diabetes if he had not become obese, and therefore, in the treatment of his case, the ration or the amount of food, should be given to him on the basis of what he should weigh and not on the basis of what he actually does weigh. This has reference to a mild case of diabetes in an obese person. So his food should be calculated on the basis of 175 pounds perhaps, instead of on the basis of 225 pounds. And in the same way, a person who has become extremely emaciated through diabetes, who has lost perhaps between 35 and 50 per cent of his weight, if he had tolerance left, should be treated gradually and as rapidly as is consistent with his progress, on the basis of what he should weigh and not on the basis of what he actually does weigh. If you treat him on the basis of what he does weigh, he is never going to improve in the way of gaining strength and weight, and a gain in weight in that type of case is of course an actual necessity, where a person has lost so much weight. So that he should be fed on the basis of 100 to 125 pounds, instead of on the basis of 85 or 90 pounds, provided only that his tolerance is high. If his tolerance is below 30 grams carbohydrate, his diet should be kept to a minimum.

Another point in the treatment of diabetes which is more and more in evidence since the Allen treatment has received such wide notice, is the fact that it has been apparently reduced to a kind of routine system of treatment. I want to warn all physicians against treating anybody in a routine manner. Directions for treatment published as the Allen method by people without experience in it, say to do such and such a thing for two days, and such and such a thing for three more days, and such and such a thing for another day. That is all very well in a few cases, but you must individualize your cases and study them carefully. I know physicians who have received diabetic patients who were practically free from sugar, and on entrance into the hospital they would put them on the general diet, and it would take them two weeks to get them free, whereas if they had individualized their patients they would not have put them on that tremendous diet, thus wasting a couple of weeks, but would have found out what they had been eating the previous two or three days, or the previous week, and determine by past history about as much as they are able to determine by pure experiment. And in the same way in the routine use of fasting. Fasting is a thing which is not necessary except in a selected group of cases. It is not necessary in the mild cases, and perhaps not wise, particularly in old people, where any radical change in the habits is liable to upset them. So that in the mild cases, and in the cases of old people particularly, we should be very chary of any extreme radical measures or fasting.

The use of whiskey and alcohol in fasting is also a thing which has come very widely into use since Allen's early publications. That again is something which is entirely unnecessary and which, I believe, in many cases does a great deal of harm, not purely on the basis of diabetes, but because these people are habitués in one sense or another, and easily become addicted to drugs. They have been food drunkards for a good many years, and if you take their food away from them it is pretty easy to substitute another habit. If they get into the habit of taking alcohol, even in small quantities, it must be admitted that they more easily throw themselves open to infections, and if there is anything that we are afraid of in diabetes it is an infection. So that no patient should be allowed to get into the habit of using alcohol if he wants to have the best chances of keeping well.

In conclusion, I would say that the treatment of diabetes is by no means a simple matter, and that it is more complicated than it ever was, although the Allen treatment has apparently reduced it in the minds of many people to a simple routine which anybody can follow. It is a subject which needs great study and great individualization, in order to obtain the best results.

Dr. L. M. Warfield, Milwaukee: Mr. President, I should like to say just a few words on this subject. There is one point in the treatment of diabetes which it seems to me, has not been sufficiently emphasized in any of the publications which have come to us, and it is a point also that was not sufficiently emphasized in Dr. Joslyn's first book, although it may be in his second

edition. Dr. Milbee did not mention it in the treatment of his cases. I refer to the exceeding danger of at once starving every diabetic patient. If you are going to treat diabetes according to the abc of Dr. Greeley, and I fully and absolutely agree with Dr. Greeley in what he says about the individualization of treatment—then there are a certain number of patients that immediate starvation will throw into a fatal acidosis. If you are going to use a routine treatment, it seems to me far better to begin with the withdrawal of fats. Then one may halve the proteins, then proceed to absolute starvation. After all it is the fat from which the acetone bodies, or the ketone bodies are produced; and if there is not enough carbohydrates in the individual to burn up his excess of fat, as Dr. Woodyatt has very prettily expressed it, the body smokes, exactly like what would happen if you gave too much oil to an automobile.

Another point that Dr. Milbee spoke about that I do not think we can all agree to, is that proteins do not produce acidosis. Now as a matter of fact, in certain diabetics, published cases and cases that probably all of us have had, the giving of proteins, after the period of starvation, when we are trying to get our patient back again to a tolerance, may produce glycosmia. So that it is perfectly evident that the individuals have a protein tolerance as well as a carbohydrate tolerance. And again, let me say that the use of the sudden starvation method as a routine in the treatment is a dangerous procedure.

Dr. L. F. Jermain, Milwaukee: I should like to direct attention to a few points in connection with this subject. I think it is becoming more and more evident, as we progress in our studies of diabetes, that the disturbance is not a disturbance of carbohydrate metabolism alone; that a disturbance of the carbohydrate metabolism may be the primary disturbance and lead to other metabolic disturbances, but that when we have a pronounced case of diabetes we are dealing with a condition which is not a disturbance of carbohydrate metabolism alone, but it is a general metabolic disturbance.

In the care and treatment of diabetes we have three objects in view particularly. The first object is to rid the patient of the excessive sugar in the blood, and of course the sugar in the urine. The second object is to determine the tolerance of that patient, not simply his carbohydrate tolerance, but his tolerance for every kind of food. Unless we do that we cannot treat our diabetic patients intelligently, and the third is to increase the tolerance of our patient. In diabetes there is a general metabolic disturbance, and we have got to determine not only the carbohydrate tolerance, but the tolerance for fats and for proteins.

Another point which was brought out by Dr. Farmer particularly this morning is that the urine is not an absolutely safe guide in determining the disturbances of metabolism in diabetes. We often meet with patients whom we know are suffering from acidosis, as indicated by their symptoms, and yet the urine does not indicate that to any very marked degree. There may be a little acetone or diacetic acid in the urine, and yet we feel that the individual is suffering from acidosis in a much greater degree than the urine—or the examination of the urine alone will indicate. So that an examination of the blood is necessary to determine accurately metabolic disturbances.

In the Allen treatment of diabetes I think it is important, as has already been mentioned, not to follow a routine text book plan. I regard that as a dangerous thing. Dr. Greeley has called attention to the fact, and Dr. Warfield has also mentioned it. This is especially true if our cases are complicated. A case of diabetes complicated by an infection, or where perhaps infection may be thought to be at the bottom of the whole disturbance, and I believe there are such cases, in which the pancreatic function may be affected, and which may be the result primarily, of an infection, must be very carefully handled, because if you put that sort of a patient on the regulation starvation treatment, you are liable to get into trouble thereby. The same is true of chronic nephritics, individuals who have for years been sufferers from diabetes, and who have developed a chronic type of nephritis. Such patients do not stand the starvation treatment well, and it is dangerous to subject them to this sudden starvation.

Snap-dragons bound to the privities of a woman in labour, causeth her to be delivered incontinent; but there must be heed taken that it be quickly removed, lest it draw forth the matrix withal.

Let that woman that is pregnant, fear to eat of the eggs of a crow; for of a surety, eating them, she shall abort of the child. (Old German folk-lore.)

To expel the newly conceived fetus from the womb of a woman, take Castor and boil it in wine or in vinegar, and drink of it morning and evening, and the fetus will come out of the womb if it be a male, but if it be a female, it will in nowise expell it.—Petrus de Montagnana.

Suffocation of the womb is an ascent of the matrix upward, on account of corrupt humours, and the cure of it is to cook the testicles of an old wolf in oil, and the same being applied to the buttocks of the woman, the suffocation of the womb of that woman shall straight be cured.—Petrus de Montagnana.

Podagra is a passion of the feet, with pains in the heels and toes, and its cure is to rub the painful part with the testicles of a wolf, and the fat of wolves, and also to wrap the body about with the skin of the same. —Petrus de Montagnana.

INDEMNITIES FOLLOWING INJURIES TO EYES: HOW SHALL WE DETERMINE THEM?*

BY VERNON A. CHAPMAN, M. D.,

MILWAUKEE.

CLINICAL OPHTHALMOLOGIST, MARQUETTE UNIVERSITY SCHOOL OF MEDICINE; ACTING OPHTHALMOLOGIST AND RHINOLARYNGOLOGIST TO MILWAUKEE COUNTY HOSPITAL AND TO MILWAUKEE INFANTS HOSPITAL; FORMERLY OCULIST AND AURIST TO HACKLEY HOSPITAL, MUSKEGON, MICH.

My apology for presenting here a paper of so little scientific nature is the fact that it deals with a problem that has confronted and will confront probably every ophthalmologist in this country and a problem that has caused much discussion and argument in many cases of Industrial Eye Injuries when the matter of indemnity was up for determination. My encouragement to present it before this Meeting is the fact that the Membership of the American Academy of Ophthalmology and Oto-Laryngology is not only the largest of all similar organizations in the world, but also the most democratic.

In these days of military activity we must not forget that we have industrial responsibilities as well. The purpose of this paper is to deal with one of these responsibilities of the ophthalmologist industrially, although the points for discussion will no doubt play a very important part in Military Ophthalmology before the Government Bureaus after the close of the war.

The determination of amount of vision remaining and the percentage amount of vision lost following injuries to one or both eyes may seem to many of you as a very simple matter and to such in particular my apology is directed. I am confident, however, that the majority of the members find this matter a real problem and to such I trust that this paper will be worth while. It is also well to speak of the percentage of loss in *efficiency* suffered by an individual on account of injury to one or both eyes. These are really very different problems which at first thought might be considered identical.

The question of loss of efficiency on account of injury to eyes is one of great magnitude and too great to be fully covered in this paper.

Dr. E. E. Holt of Portland, Maine, has worked out an ultra scientific method of computing the loss of efficiency due to loss of different portions of the field of vision in one or both eyes as well as efficiency loss due to reduction in acuity of central vision, and also that due to loss of use of one or several of the muscles of one or both eyes.

Every case presents individual points for consideration and must be decided upon its own peculiar merits. Loss of efficiency on account of loss of vision caused by occupational *diseases* (Distinctly not accidents) effecting the eyes, is a matter that requires special study. The results following some injuries may cause considerable loss of general efficiency in an individual and not particularly impair his efficiency in some certain line of work.

Loss of one eye would seriously affect stereoscopic vision; yet a watch maker or a master of fine engraving does excellent work with a single eye and glass.

Some State Industrial Accident Commissions rate the loss of efficiency by the individual's ability in actual earning power after injury as compared to the earning power before injury.

An eye may have enough remaining vision to enable its owner to do certain kinds of work but not enough to enable him to do the kind of work he was doing before the injury.

It does not necessarily follow that the man who has lost an eye is totally and permanently reduced in efficiency and earning power. He may turn to a different vocation in which by diligent application he may so cultivate his faculties that with his remaining eye his earning power is greater than before. Pennsylvania recognizes this and solves the problem by providing that "For the Loss of an Eye an employe is entitled to compensation for 125 weeks at the rate of 50% of his wages. For partial loss of an eye he is entitled only to 50% of his wages during total disability. If however, upon returning to his work he is unable to earn as much as he did previous to his accident his employer must pay him 50% of the difference in his earning power for a period not exceeding 300 weeks or until his earning power has increased in the amount equal to that previous to the injury."

Facial disfigurement may add to an individual's loss of efficiency in the competitions of life. Is an

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eye of unsightly appearance a *facial* disfigurement? If so there must be a wide range of ratings on such. From merely the deviation of an amblyopic eye, the globe of which is of normal appearance, through the various cosmetic results caused by a chronic congestive conjunctivitis; the white pupil of a traumatic cataract; epiphora following destruction of lachrymal canals; coloboma of lids, enucleation of globe, with or without prothesis, to total destruction of the globe and orbit. Again what position should we take regarding facial disfigurement where an artificial eye is worn following enucleation? Clearly, the wearing of a well fitting artificial eye reduces disfigurement to a great degree but does not entirely eliminate it. Many disfigurements of the eye and its appendages are amenable to plastic surgery.

I have a case wherein I was enabled to eliminate an old disfiguring coloboma of upper eyelid by inlaying a piece of skin with hair from the eyebrow. Even living eyelashes were supplied. This case is to be reported at length together with other cases of plastic eye work and is mentioned here only to show that not all facial disfigurements are necessarily permanent even though existing for years. An eye may be blind without contributing to disfigurement. An eye or its appendages may contribute largely to disfigurement without serious impairment of vision. E. g. Ectropion; yet if this ectropion persists the vision may be impaired as a consequence.

Damage to an eye or its appendages or vision may occur as remote result of an injury to a different structure. Paralysis or blindness following injury to skull or brain. Epiphora following injury to nose. Ectropion due to contracting of scar following injury to the face.

There is opportunity for much difference of opinion regarding statements in accident insurance policies. State Industrial Laws, and others, concerning damage to eyes, on account of the different words and expressions used interchangeably which permit of different interpretations. These should be made more uniform with exact definitions. There is a possible chance for difference in the interpretation of what is meant by "vision" and by "sight". I would interpret vision as the ability of the eye to determine the relative size, shape and color of objects by means of light. Sight being the power of recognizing light and thus distinguishing between light and darkness. Vision is lost when the relative size, shape and color of objects can no longer be determined by an eye. Sight is lost only when an eye can no longer determine between light and darkness—absolute loss of light perception. With the eyelids closed over the eyes the normal eye can distinguish between light and darkness and can perceive that the hand passes between it and the light, but it can not tell the relative size, shape or color of the hand. The sight remains; the vision is gone.

The position has been taken by accident insurance officials concerning policies providing indemnity for "total loss of an eye", "That the eye is not totally lost as long as there is any light perception remaining." Hence, benefits do not apply.

The following questions are frequently put to the Ophthalmologist in court and in private settlement of claims following eye injuries and in interpreting the law: What is—"Loss of an Eye;" "Loss of Vision;" "Loss of Sight;" "Blindness?" Each in a degree total or partial; and if partial to what percentage of total; or of normal?

The expressions "Vocationally Blind," "Industrially Blind," and "Totally Blind" are subject to different interpretations. The only term describing the percentage of blindness which seems to be universally accepted as to its meaning and admits of no equivocation is the expression "Stone Blind".

Upon the proper interpretation of these terms and conditions depends in a great measure the ability of Industrial Boards, Accident Insurance Companies or other Judicial Bodies to administer with equal justice. The lack of uniformity is apparent on studying the industrial Accident Compensation laws of different states.

Utah provides indemnity for loss of an eye and makes a distinction between loss of an eye "by enucleation" = 120; and "Total Blindness" = 100. Utah also considers total blindness of both eyes as total and permanent disability; but, makes no provision converning facial disfigurement. Mr. P. A. Thatcher, Chairman of the Utah Industrial Commission writes: "There is nothing prescribed in our Act for the partial loss of vision . . . and up to the present time we have not had occasion to hear any case where the partial loss of vision has been a consideration."

Minnesota provides indemnity "for loss of an eye" and also provides that "the total and perma-

nent loss of the sight of both eyes . . . shall constitute total disability."

Quoting from a later statement by the Department of Labor and Industries of Minnesota: "The amount of compensation . . . depends upon the percentage of loss of vision which he (employe) has sustained."

I have been unable to get information as to how this vision percentage is determined by the Minnesota Board.

Pennsylvania provides compensation "for the loss of an eye". "The Workman's Compensation Board has ruled on several occasions that an employe is not entitled to compensation for the loss of an eye unless the vision of same is entirely destroyed." Thus it is very important to definitely determine when *vision* is, or is not, "entirely destroyed."

Wisconsin provides indemnity "for loss of an eye by enucleation 160. For loss of the second eye by enucleation 320. For total blindness of one eye 120. For total blindness of the second eye 240." Total blindness of both eyes is considered as equivalent to, and rated the same as, Total Disability. It does not specify just what is meant by "Blindness" and here again is need for a positive definition of the word "Blindness". Wisconsin also provides indemnity for facial disfigurements.

Connecticut in providing compensation in case of eye injury provides that "Total and permanent loss of sight in both eyes, or the reduction to one-tenth or less of normal vision with glasses" . . . "Shall be considered as causing total incapacity and compensation shall be paid accordingly." Regarding injury to one eye provision is made "For the complete and permanent loss of sight in one eye or the reduction in one eye to one-tenth or less of normal vision with glasses".

There is no limit put upon the dioptre strength of lenses necessary to bring vision to as near normal as may be. Therefore, single or double traumatic cataract could be operated and correcting lenses worn and the vision would be increased to such an extent that the compensation covering traumatic cataract in Connecticut would be no more than half it would be in Oregon where traumatic cataract is considered as total loss of an eye.

Connecticut does not fix a specified amount payable in percentage of the whole according to percentage lost, in cases of partial loss of vision. It generalizes all injuries causing partial incapacity and, like Pennsylvania, provides the indemnity, "equal to half the difference between his average weekly earnings before the injury and the amount he is able to earn thereafter;" apparently irrespective of the percentage of vision remaining; and also not limiting the earning capacity to the same kind of work done before the injury, but permits the employer to procure for the injured employee employment "suitable to his capacity".

Colorado provides indemnity for "total loss of an eye by enucleation 139", "for total blindness of one eye 104," with provision that "in all other cases . . . the compensation shall bear such relation to the amount stated . . . as the disabilities bear to those produced by the injuries named". Colorado therefore does make a distinction between "loss of an eye" and "total blindness of one eye". Provision is made for indemnity covering serious permanent facial disfigurement.

Ohio provides indemnity "for the loss of an eye" at the same rating that it provides for permanent total disability, limiting the period over which indemnity is to be paid. It does not specify what is meant by "loss of an eye".

Nevada specifies that "the total and permanent loss of sight of both eyes" shall be considered "total and permanent disability" "in absence of proof to the contrary". This State provides indemnity "for the loss of an eye" and explains that "the permanent and complete loss of sight in one eye may be deemed as the loss of one eye". And, "in all cases of permanent partial disability, not otherwise specified in the foregoing schedule, the percentage of disability to the total disability shall be determined". Nevada also makes a distinction with reference to "a disability that is partial in character but permanent in quality". "Where a percentage loss of vision is reported to the Commission by the eye specialist, to whom the claimant was referred, the compensation awarded is determined by multiplying the percentage loss of vision by the compensation for the total loss of vision. Loss of 90% of the vision of an eye is considered as total loss of the eye".

There is a provision as follows: "Where there is a previous permanent disability as the loss of one eye . . . the percentage of disability for a subsequent injury shall be determined by computing the percentage of the entire disability and

deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury."

Nevada provides a further indemnity under the heading of "Facial disfigurement". "For permanent disfigurement about the head or face which shall include injury to or loss of teeth."

Montana provides indemnity for the loss of "one eye by enucleation" 120; and for "total blindness of one eye" 100. There is provision made for compensation for injury producing "temporary total disability" and, "for an injury producing total disability permanent in character" and, "for an injury producing partial disability." Presumably these provisions apply to injuries to eyes as well as to other parts of the body. I find nothing specified regarding facial disfigurements.

Oregon considers "total loss of eye sight" as permanent total disability, and, "loss of one eye" as permanent partial disability. Later in the same section of the law reference to this permanent total disability is made as "the permanent and complete loss of the sight of one eye". Upon inquiry I learn that in Oregon traumatic cataract is considered total loss of vision and the same award made as for total loss of the eyeball. This is unfair. A man with traumatic cataract has not suffered nearly as much loss as has one with globe entirely destroyed. The former is not a total permanent irretrievable loss as is the latter.

The following letter received in reply to mine is interesting: "Replying to your letter of recent date to the State Industrial Accident Commission relative to the method of determining in terms of percentage the loss of vision a workman may have suffered. I will say that where an injured workman has lost some vision as a result of accident, the case is allowed to remain for three or four months after treatment has ceased in order that one may be sure that there will be no further improvement or loss of vision and then the eye is tested for distant vision taking 20/20 as a standard, or equal to 100%. If the party's vision should be found to be only 10/20, it would be considered that he had lost ½ of the vision in that eye, etc.

Where there is a loss of useful vision and only perception of light remains, the vision of the eye is considered as totally lost and award made accordingly.

In cases of traumatic cataract, the Accident Commission does not insist upon an operation to restore vision because that eye would be aphakic and would not therefore accommodate with the other eye, so in this case the injured workman would be paid for the loss of vision. The same award is made for total loss of the eye-ball as is made for loss of vision.

I realize that sometimes these cases must be determined rather arbitrarily, as for instance in a case of contracture of the field vision, due to skull fracture where the perimeter record will show good central vision but very little vision outside of central vision, such a party might be able to do office work as well as before the accident but certainly could not go out into the woods and work at logging as he did before.

Then to state in general terms, normal vision considering it at 20/20, we rate as 100% and estimate the loss of vision by test of vision at 20 feet with the regular test type, converting the fraction into 100ths in order to make the estimation of percentage more convenient."

Oregon furnishes a very complete well designed blank for eye surgeon's special reports on accident cases.

Wyoming provides indemnity "for loss of an eye". Provision for "temporary total disability" is made but "as soon as recovery is so complete that the earning power of the workman *at any kind of work* is restored the payments shall cease". "Total loss of eyesight" is considered permanent total disability. "Where there has been a previous disability as the loss of one eye . . . the percentage of disability for a subsequent injury shall be determined by deducting therefrom the percentage of the previous disability as it existed at the time of the subsequent injury."

Michigan provides compensation for loss of an eye. "The law in this State (Michigan) relative to eye cases was settled in the case of Hurschkorn vs. The Fiege Desk Company. Page 206 Michigan Workmen's Compensation Cases, 1916. In this case it was held that there had to be a total loss of vision, or over 90% before it would be considered loss of vision. No compensation is paid for partial loss of vision, other than what is paid for the time lost, except in cases where the earning power of the employee is decreased. The loss of

vision in both eyes is considered total disability. In cataract cases the Industrial Accident Board take into consideration the fact that the eye upon which the operation is performed is only a reserve eye and will allow settlement on a partial loss of vision basis." A statement that is somewhat ambiguous.

Oklahoma under "Permanent Partial disability . . . disability partial in character but permanent in quality" provides compensation "for the loss of an eye"; and states that "Permanent loss of the use of . . . an eye shall be considered as the equivalent of the loss of such . . . eye."

California has a very elaborate set of ratings and tables by reference to which, four items being first determined, the compensation to a workman for any particular kind of injury at any particular kind of employment can be accurately determined. These four items to be determined accurately as soon as possible after injury are:

"1. The nature of the physical injury or disfigurement.

2. The occupation of the injured person.

3. The age of the injured person.

4. The average weekly wage of the injured person.

The list of results of eye injuries specifies as follows:

"Complete loss of both eyes.

Complete loss of the sight of both eyes.

Complete loss of one eye.

Complete loss of the sight of one eye.

Complete loss of the sight of one eye, plus such impairment of the sight of the other as prevents reading or writing but not the ability to find one's way:

Slight—Moderate—Severe—(The degree to be determined by aid of medical advice.)

Loss of the sight of one eye leaving no scar or blemish such as would afford an observer evidence of such loss.

Permanent impairment of the vision of both eyes to the extent of rendering them useless for purposes of high visual requirement, but not for finding one's way:

Slight—Moderate—Severe—(The degree to be determined by aid of medical advice.)

Such a permanent impairment of the vision of one eye as renders it useless for purposes of high visual requirement, but not affecting one's ability to find one's way, the other eye being uninjured.

Hemorrhage of the eye, causing defective vision at times only.

Paralysis of the muscles of both eyes by reason of injury to the sockets causing double vision.

Paralysis of the muscles of one eye by reason of injury to the socket of that eye, causing immobility and double vision.

Injury to the eye-socket, causing immobility of eyeball with attendant impairment of range of vision only.

Laceration of lachrymal duct, causing chronic overflow of tears;" and provides definite compensation according to the four cardinal items above stated for each one.

A recent change in the California Act provides that "The Term 'Injury' as used in this act shall include any injury *or disease* arising out of the employment. In case of aggravation of any disease existing prior to such injury, compensation shall be allowed only for such portion of the disability due to the aggravation of such prior disease as may reasonably be attributed to the injury".

This provision makes it important that all employees pass through a physical examination before being put to work.

California provides under ratings for injuries to the face "Such injuries of the nose and face as by reason of the disfigurement, make the injured person so repulsive as to interfere with his ability to compete in obtaining employment, there being no permanent functional impairment", in three degrees of severity: Slight, Moderate and Severe, with a separate rating for each, according to the four cardinal items.

The California act specifies that "Remediable injuries will not be considered permanent until all adequate and reasonable operations and treatments known to medical science have been used to correct the results".

"The law allows unlimited medical cost to meet this case" recognizing that "It is better to correct the trouble than to continue payments for permanent disability due to lack of attempts at correction".

A number of years ago I pointed out in an Editorial in the Journal of Michigan State Medical Society the necessity of examining the eyes of prospective employees before they are taken into employment. The wisdom of this course as a routine has been demonstrated many times. Some large employers of labor are doing it and I can not understand why some are not. I believe there will come a time when a bureau will be established which will provide accurate information from records to all employers of labor and Industrial Commissions concerning the physical condition of any one whom they are about to employ or about whom such information is needed. A clearing house by means of which the employer will not only receive protection in case of industrial accidents, but, knowing the physical condition of the man he is hiring, especially as to his vision and hearing, will be able to place the man at proper work to the mutual advantage of both employer and employee. Until such time when something of this sort is done, we are bound to accept the vision as normal before injury; lacking proof to the contrary.

It appears to be generally conceded that a reasonable period of time should elapse between recovery of an injured eye and the final testing of its remaining vision in order to learn whether the vision is going to become better or worse as the case may be so that the final vision test may be made with the eye at its probable mean level of efficiency. It is also permissable to use correcting lenses in determining the remaining vision. Some restriction should govern this however, as pointed out in the report of the Chicago Ophthalmological Society's Committee last January. This Committee composed of Drs. Harry Gradle, Frank Brawley and Harry Woodruff, recommended that there should not be a difference in spherical strength between the correcting lenses for the eyes of an individual to exceed 4 Dioptres.

Accepting as full vision the standard Snellen letter that subtends an angle of 5′ on the retina, normal vision may be represented by the fraction 20/20. The numerator representing the distance in feet at which the eye under test actually sees the letter or test object and the denominator the distance at which it should see it if normal. Any increase in the denominator means a loss in vision certainly and any fraction thus formed represents a certain definite amount of vision. But what does it represent in percentage of full vision? This must be determined if we are to fix a definite percentage of indemnity due for partial loss of vision in an injured eye. Suppose that a man has vision of 20/40 with a correcting lens, in an eye at recovery from its injury. He had 20/20 vision before injury. Arithmetically speaking 20/40 is half of 20/20; *but* it does not follow that the man has lost 50% of his vision. It is impossible to establish a percentage without two fixed points; one high and one low. All points between these are definite percentages of one or the other as the case may be. 20/20 vision may be considered as 100%. We must establish some definite amount of vision as O.

What constitutes total loss of an eye? Whether an eye must be actually lost in the sense that a finger is lost, i. e., by separation from the body; or whether it is only necessary that vision be absent, the globe remaining. If the latter, then must there be complete loss of light perception before vision may be considered totally lost? If not, then how much remaining perception may an eye have and still be considered as having vision lost? This can only be fixed arbitrarily. I suggest that it be 20/220 vision.

There are probably certain areas or islands in the vision scale between 20/20 and 20/220 in which the vision so represented is of more value than others; and of different value in different individuals according to the principle use to which the eye is put. Dr. Parker points out that "failure of vision from just inside to just outside ability to read should have decided difference in percentage loss".

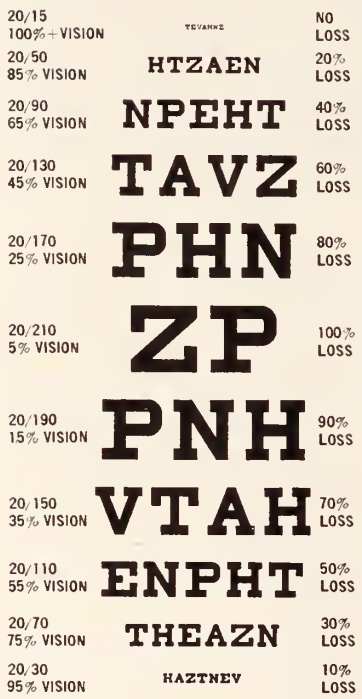
The personal value of remaining vision to an individual really increases very much as it approaches total blindness. This can only be fully appreciated by the totally blind.

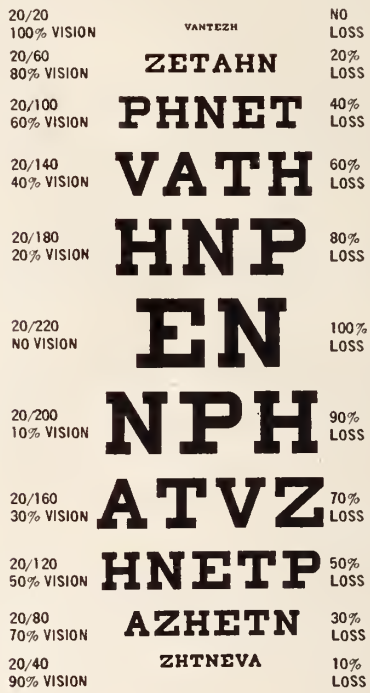
I suggest the following table as a working standard for determining vision in percentage:

20/15	= 100%	+ Vision	=	Superexcellent Vision.
20/20	= 100%	Vision	=	No Loss of Vision.
20/30	= 95%	Vision	= 5%	Loss of Vision.
20/40	= 90%	Vision	= 10%	Loss of Vision.
20/50	= 85%	Vision	= 15%	Loss of Vision.
20/60	= 80%	Vision	= 20%	Loss of Vision.
20/70	= 75%	Vision	= 25%	Loss of Vision.
20/80	= 70%	Vision	= 30%	Loss of Vision.

20/90 =	65%	Vision =	35%	Loss of Vision.
20/100 =	60%	Vision =	40%	Loss of Vision.
20/110 =	55%	Vision =	45%	Loss of Vision.
20/120 =	50%	Vision =	50%	Loss of Vision.
20/130 =	45%	Vision =	55%	Loss of Vision.

It would make a large unhandy chart if this whole table test were printed upon one card. It has therefore been arranged upon two cards each with ten lines above and ten lines below the central letters as follows:



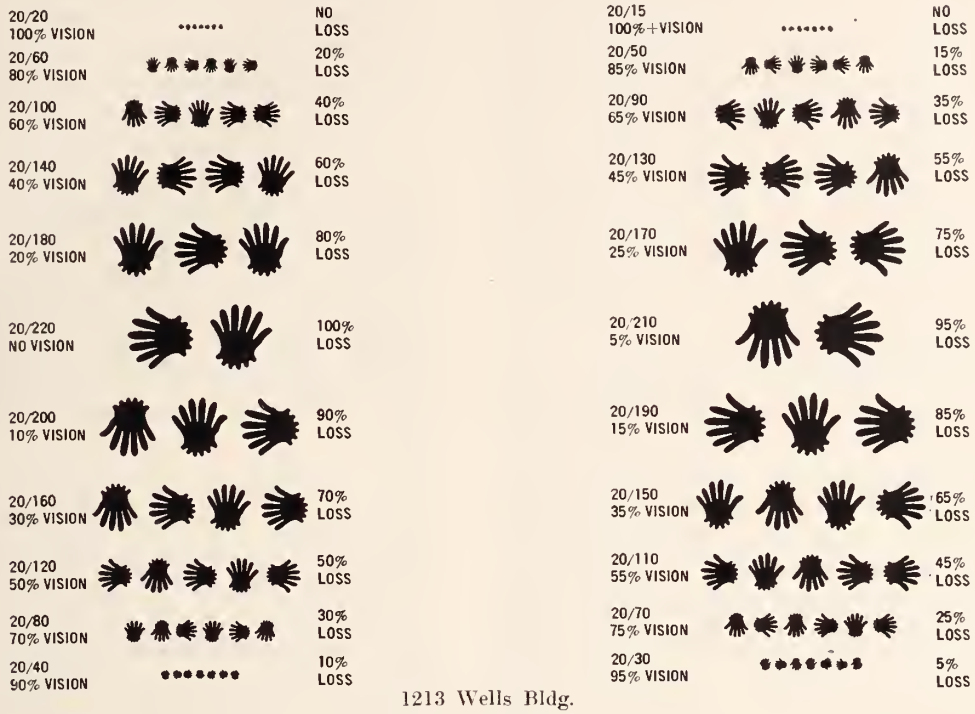


20/140 =	40%	Vision =	60%	Loss of Vision.
20/150 =	35%	Vision =	65%	Loss of Vision.
20/160 =	30%	Vision =	70%	Loss of Vision.
20/170 =	25%	Vision =	75%	Loss of Vision.
20/180 =	20%	Vision =	80%	Loss of Vision.
20/190 =	15%	Vision =	85%	Loss of Vision.
20/200 =	10%	Vision =	90%	Loss of Vision.
20/210 =	5%	Vision =	95%	Loss of Vision.
20/220 =	0%	Vision =	100%	Loss of Vision.

I would suggest that test charts covering this entire range of vision would be aids in arriving at a definite conclusion. If such charts were made I would suggest further that they be arranged with the largest types or devices in the center and the other lines placed above and below the center alternately as they range in the scale so that the chart be read up and down from the center. This arrangement gives the chart a certain value in detecting malingereres who insist on recognizing only a certain number of lines from the largest. Letters, numerals, or devices may be used.

There is need for an illiterate chart in testing the vision of foreigners and uneducated laborers. I have never yet seen an illiterate test chart that satisfied me and I have tried many during several years work as examiner for the Public Schools of the city of Muskegon. Not that they are inaccurate particularly, but because they require too much explanation in teaching the subject what he must do in order to use them. There is no letter, number, device or object with which the child or illiterate person is so familiar as the human hand. His own hand if you please; and I believe that a picture of the hand is the best device to place on an illiterate chart. The space between the thumb and first finger is too great in proportion to the space between the other fingers. I have therefore inserted an extra finger in that gap. The illiterate will not stop to count the fingers and only recognizes the picture as an open hand with the fingers pointing in a certain direction. It is very simple for him to hold his own hand up in a manner corresponding to the hand on the chart.

We have then the six fingered hand turned in different directions with a scalloped gauntlet cuff masking the proximal end of the hand in order to make it, as much as may be, no more readily distinguishable than the distal end. This device I have arranged in the same manner as the letters on the table charts: Thus,



1213 Wells Bldg.

THE RIGHT UPPER ABDOMINAL QUADRANT.*†

BY VICTOR F. MARSHALL B. S., M. D.,

SURGEON TO ST. ELIZABETH HOSPITAL,

APPLETON, WIS.

This particular region of the human organism presents many problems of interest to both the internest and the surgeon. The diagnosis of lesions in this particular field is not always a simple matter and even though the diagnosis be made satisfactorily the necessary measures to bring about relief and cure of the patient may be difficult and even impossible. The all important factors are to interpret correctly the symptomatology, to recognize the gravity of the situation and advise and promptly institute the necessary surgical procedures.

The remarks which are to follow are based upon a personal experience of a total of 239 cases and grouped as follows:

The biliary tract: total number of 130 cases.

Age—youngest 16 years—oldest 80 years.

Sex—15 males—115 females.

Number with cholelithiasis without any other complications, 73 cases, among which there were 8 cases of hydrops of the gall bladder. There were 10 cases of empyema of the gall bladder. 3 cases concomitant with pregnancy, of 5, 6 and 8 months duration. There was one ruptured gall bladder. Local anesthesia was used in 6 cases. In one case (Mrs. B.) more than a 1,000 calculi and the appendix were removed with the anesthetic.

Cholecystectomy was performed in 46 cases—the common procedure was carried out in 44 cases and the retrograde procedure in 2 cases. There were 7 cases of jaundice and stones found in the common and the hepatic ducts. One case had myraids of stones in the cystic, common and hepatic ducts. One case operated upon again within 3 weeks for stone in the common duct following cholecystectomy, gastroenterostomy and appendectomy. 14

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*Read before the Outagamie County Medical Society.

†In my early experiences many cases were diagnosed as those of a gastric ulcer, which in reality were duodenal and which would account for preponderance of gastric ulcer over duodenal ulcer in this paper.

cases had either gastric or duodenal ulcer requiring operative interference. Two had the gastric ulcers excised in which omental flaps were grafted over the aera. 12 had posterior gastroenterostomies. A very large percentage had the appendix removed at the same time in which the surgical procedures to the gall bladder was done. 12 cases were operated upon in private homes, the remainder in hospitals. One case had 8 stones in the common duct. There were 14 cases of cholecystitis (so-called strawberry bladder) and cholangitis without stone formation. One case had a very acutely inflamed gall bladder without stone formation. There were 10 cases of carcinoma of the gall bladder and ducts. There were 8 cases operated upon previously (cholecystostomy) with recurrences. Analyzing these: one operated upon 3 years previously with per sistent fistula—a stone was found in the cystic duct; one 5 years previously with persistent fistula, a stone was found in the cystic duct; one operated 6 years previously with persistent fistula, a cystic duct stone was found; another operated 8 years previously had jaundice, and upon operation a stone was found in the cystic duct causing pressure upon the common duct. Three cases revealed stones in the gall bladder and the fourth a bladder filled with cholesterin. There were 2 cases with accompanying pancreatitis. One died, the other recovered. There were 3 cases of common duct stones without jaundice and in another case stones were found in the hepatic duct and without jaundice. In this series there were two sisters and a brother with cholelithiasis for which cholecystectomy was done.

GASTRIC AND DUODENAL ULCER—91 CASES.

At a previous meeting of our society a report of 85 cases was made and I now wish to report 6 more. There were 39 cases duodenal ulcer, and 52 cases gastric ulcer. 12 cases of acute perforation. One case a perforation of a duodenal ulcer followed a week later by a perforation of a second duodenal ulcer which was noted at the primary operation. In 8 cases the ulcer was excised; in 2 cases pylorroplasty followed excision of the ulcer. One case of entro-enterostomy 2 weeks after primary posterior gastro-enterostomy for persistent regurgitant vomiting appearing on 12th day after operation. One case the stomach was opened upon three different occasions for; first, pyloric ulcer; second, removal of linen suture which had been used at first operation; third, excision of acute ulcer, with hematemesis, formed in the previous line of gastric opening. There were 3 cases of severe gastric hemorrhage following operation; one occurred second day after operation and who died; a second case occurring first day after operation in which cholecystectomy and appendectomy and posterior gastroenterostomy were done and who recovered. A third case hemorrhage occurred 10 days after operation (posterior-gastroenterostomy) and who recovered. There were 6 cases of carcinoma of the pyloric end of the stomach. There were two cases of traumatic rupture of the liver; one died, the other recovered. One case of intestinal obstruction in which the obstruction about the duodenum was due to a band from a previous operation to the gall bladder, several years before.

Two cases of acute pancreatitis—both died. There were two cases of acute appendicitis and three cases of the recurrent form, in all, the appendix had failed to complete its journey to the right iliac fossa, being arrested in the region of the gall bladder. There was one case of pronounced acute adenitis of the lymphatic glands in the region of the gall bladder and duodenum; the case occurring in a male, 11 years of age. One case of carcinoma of the colon at the hepatic flexure.

We may proceed to discuss these pathologic conditions of the right upper abdominal quadrant by assigning them to either the acute or chronic abdomens. Under the first classification, we would assign acute inflammatory, perforating and gangrenous cholecystitis: perforating duodenal and gastric ulcers; acute inflammatory, perforations and gangrenous appendices; acute hemorrhagic pancreatitis; acute intestinal obstruction and finally an acute adenitis of the lymphatic glands in the region of the gall bladder. Chronic abdomens involving the right upper abdominal quadrant would include, cholecystitis, cholongitis and cholelithiasis, pancreatitis, duodenal and pyloric ulcer, recurrent appendicitis, carcinoma of the colon at the hepatic flexure.

The important point of differentiation between the acute and chronic abdomen is one of history, but for accurate diagnosis, we must resort to all means at our command. A history of the patient whose illness begins with a sudden, acute onset, sudden local pain, vomiting and shock, with perhaps an elevation of temperature presents a differ-

ent picture than the one who is ambulatory, with either local or diffuse pain, nausea and vomiting and no elevation of temperature and the absence of shock.

Let us consider the various symptoms in detail, the first of which is pain. Pain which may be defined as an expression of a circumscribed or diffuse inflammation of one of the internal organs.

Pain may be sudden in onset or gradually develop. It may be local, diffuse or referred. A marked rigidity of the abdominal muscle is usually indicative of pain and inflammation. A localized pain in the epigastrium, and sometimes referred to the back, we usually interpret as significant of a lesion in the stomach. Pain referred to the right of the epigastrium is usually interpreted as of duodenal origin. Pain about the costal arch and referred to the epigastrium, or associated with radiations to the right shoulder or arm, and back and very frequently to the right iliac fossa, we interpret as being biliary in origin. The acute perforating gastric or duodenal ulcer is ushered in with pain, intense and stabbing in character which is referred to the upper abdomen, the abdomen soon assuming a board like rigidity. It is not always possible to make a positive pre-operative determination (or is it important) of the position of a perforating peptic ulcer.

The initial pain of an acute cholecystitis is epigastric in location but soon localizes in the right hypochondrium.

The pain of an appendicitis is usually sudden and local in character.

The pain of an acute fulminating pancreatitis usually first appears in the epigastrium and radiates to the left, the pain being agonizing and constant. All intra-abdominal conditions of this region which are accompanied by shock and collapse, of which acute hemorrhagic pancreatitis stands at the top, indicates the seriousness of the lesion and the peril of surgical delay.

The pain of an intestinal obstruction, intestinal obstruction constituting about 25% of the causes of the acute abdomen exclusive of intussusception, is also usually referred to the epigastrium.

It is interesting to note, that when an ulcer of the duodenum develops first, the pain is to the right of the epigastrium associated with tenderness in the duodenal area. The pain develops one or two hours after partaking of food and is relieved again by the taking of food. When in the presence of such an ulcer of the duodenum, a gastric ulcer develops, the pain of the latter appears in the foreground and covers the pain induced by the duodenal ulcer. The pain of a gastric ulcer, comes on immediately after meals and runs over, merges into and becomes continuous with the pain of the duodenal ulcer, coming on one or two hours after meals. We may then make the statement that in the presence of a stomach ulcer, pain arises on taking food which in the presence of duodenal ulcer pain is relieved by the ingestion of food. We can therefore make a double diagnosis when the duodenal ulcer develops first, but not vice versa.

Nausea and vomiting—These symptoms following pain appears in all acute lesions of the right upper quadrant and frequently occur in chronic affections of this region. Vomiting occurs in acute appendicitis, acute cholecystitis, perforating gastric or duodenal ulcers, acute pancreatitis and in acute intestinal obstruction.

In acute appendicitis and acute perforating gastric and duodenal ulcer they may vomit but once, while in acute intestinal obstruction the vomiting may be continuous. Nausea is a symptom which accompanies most of the chronic conditions of this region. Patients with ulcers of the duodenum not associated with complications do not vomit. In ulcer of the duodenum associated with vomiting, there is usually a peri-duodenitis, an attempt at perforation, a circumscribed peritonitis, an infected gall bladder, or a complicating ulcer; in other words it denotes an irritation of the peritoneum. Where gastric ulcer is a complicating factor, food contents alone are vomited. Where the biliary tract, or a circumscribed peritonitis is at fault, there is a tendency toward the vomiting of bile.

Temperature is indicative of infection and is the result of the absorption of toxic substances. In all acute conditions of this region, temperature may be subnormal at the onset, normal and a few hours later may be elevated. In acute appendicitis an elevated temperature may be present from its onset. In rupture and gangrene of the appendix, the temperature may subside, only to become elevated a few hours later, to a degree as high, if not higher, than in the beginning.

An elevated temperature is present in acute cholecystitis. The marked subnormal and high elevations of temperature in stones of the common duct, is well known. I refer now to the "Steeple

Chase" temperature. In acute perforating gastric or duodenal ulcers, the temperature at first is not disturbed but with the escape and gravitation of the fluid, the temperature soon rises.

The temperature in an acute hemorrhagic pancreatitis is, at first, subnormal and later, as the septic products are absorbed becomes elevated, reaching as high as 106 degrees and even higher.

The temperature of an acute intestinal obstruction is not affected until the bowel wall has lost its tonicity and the infection invades the peritoneal cavity.

Pulse—We can make the statement that the pulse, in a chronic abdomen, is not affected to the same degree as that in an acute abdomen. In the acute abdomen, which is ushered in with shock and collapse, the pulse is slow and of low tension, but later, as the condition of reaction ensues and with the absorption of toxic substances the pulse rate soon rises to a frequency proportionate to the temperature and in many cases out of all proportion to the same.

Bowels—In a large percentage of cases in appendicitis the condition of the bowels remain undisturbed. There may be obstinate constipation, simulating bowel obstruction, as a prominent symptom of the acute fulminating cases. In a small percentage of cases a diorrhoea may be present. Patients with gall stone disease are as a rule, not troubled with constipation. While patients with duodenal or gastric ulcer are invariably so.

The bowels are obstinately constipated in an attack of acute pancreatitis and for this reason the case is often mistaken for one of intestinal obstruction.

In intestinal obstruction the lower bowel may be emptied but there is total obstruction of the upper bowel to gas and intestinal contents.

A word about Shock and Collapse—This condition ushers in and is always present, in perforations due to gastric and duodenal ulcers, perforated gall bladders, acute hemorrhagic pancreatitis and acute intestinal obstruction. It denotes sudden trauma to a normal peritoneum and the intensity of absorption of highly toxic products.

Let us touch upon *muscular rigidity.* Muscular rigidity and tenderness on palpation are almost identical. In some certain conditions of an acute abdomen, as in acute perforating duodenal and gastric ulcer, or in perforating gall bladder, acute intestinal obstruction, the abdomen is board like in rigidity and once seen, can never be forgotten.

In the chronic abdomens, where more or less peritoneal irritation is present, as in cholecystitis, cholangitis, cholelithiasis, duodenal and gastric ulcers, recurrent appendicitis and pancreatitis, the muscles of the upper abdomen are in a state of some rigidity.

Facial expression—In all pathologic conditions in this region, which are inflammatory in nature, with the accompanying pain is reflected in the facial expression. The degree of expression may vary, from a look of slight anxiety in the mild cases, to the severe agonizing and distorted features as depicted in an acute hemorrhagic pancreatitis.

History—Whenever possible a painstaking history, carefully analyzed will throw considerable light, on some obscure condition confronting the internest and surgeon. The appendix rarely perforates without some premonitory attacks. Oftentimes these previous attacks may be so mild in character as to have been interpreted as simple constipation. Cholecystitis without stones is usually accompanied by habitual tenderness in the region of the gall bladder. As a rule, colic is not a prominent symptom and if present is not so severe in character as the accompanying gall stones. In some cases of cholecystitis there is often a mild constitutional disturbance and in some instances, for months at a time, there will be a slight elevation of evening temperature (99-100 Degrees), but without marked loss of flesh, the patient complaining of lassitude and other symptoms of a chronic mild tozemia. Patients suffering with peptic ulcer may complain of eructations of food, burning sensations in the epigastrium, a peculiar distress in the gastric area. There may be pain after partaking of food, nausea and vomiting, and there may be loss of weight. These symptoms, with an aggravation of the same, in those months when throat and mouth conditions prevail are usually suggestive of some lesion of the upper intestinal tract.

Pathologic changes—The appendix may show any change from a simple injection of the submucous and muscular layers, to an intensely swollen, discolored, necrotic condition studded with military abscesses, a single large abscess, an enterolith with a destruction necrosis of its walls and a consequent perforation. The specific area

involved may be any point, between the base and the tip of the organ.

Hepatitis—This condition is admirably expressed by Evarts A. Graham, in a recent issue of Surgery, Gyn. & Ob. Journal and which will quote:

"(1) In cases of acute or subacute cholecystitis there has been constantly found in the liver microscopical evidence of inflammation.

(2) The hepatic inflammation is characterized by leucocytic infiltration of the interlobular, or periportal, sheaths; in the more severe types of inflammation the infiltration may involve also the parenchyma at the peripheries of the lobules and be associated with more or less oedma, slight necrosis, and moderate fat infiltration.

(3) Cultures from both the liver tissue and from the bile in the gall bladder have usually revealed the same organism in each case.

(4) In chronic cholecystitis, sections of liver tissue often shows a picture practically identical with that of an early case of cirrhosis.

(5) The inflammatory reaction in the liver is apparently chiefly a pericholangitis.

(6) The gross enlargement of the liver is probably usually due chiefly to oedema.

(7) Generally the liver will subside to normal dimensions after sufficient time has elapsed following appropriate surgical treatment, although in some of the more chronic cases only a marked diminution in size has occurred after nearly a year instead of a complete return to normal dimensions."

The gall bladder usually shows either one of two principal changes in its walls, which follow infection. The first may be more or less cellular infiltration, followed sooner or later, according to the number of attacks, by a thickened condition of gall bladder wall so that it loses its property of contractility. The second we have changes of an ulcerative type. Ulceration may be superficial and only involve isolated areas of mucous membrane—the so-called "strawberry" gall bladder. Or destruction extends through the entire thickness of gall bladder wall and is followed by a secondary cicatricial contraction, converting the entire gall bladder into a rigid, thinned out structure with consequent loss of contractility and resultant stagnation of its contents. The crypts of Luschka, have been found to contain organisms even after long continued drainage and calculi may form in these dilated crypts. It is now a well known fact that most cases of cholecystitis are the result of a hematogenous infection of the wall of the gall bladder—the primary focus being either in the appendix, teeth, tonsils, accessory sinuses, etc. Biliary tract infections become also foci of distribution.

Gastric and duodenal ulcers may be single or multiple in number and be present simultaneously. The ulcer involves the mucous membrane down to the muscularis layer and is variable in size and shape. The tissue surrounding it may be more or less infiltrated and the adjacent glands, hypertrophied. When perforation occurs the opening may be pin point in size and in some cases as large as a quarter dollar. Gastric and duodenal ulcer are the end products of infection.

Acute pancreatitis may appear in one of three types, according to Deaver. The first or ultra-acute type shows profuse hemorrhage into the organ and its surroundings. This type is rapidly fatal. The second type shows the hemorrhage to be not so severe and the destruction of the organ not so complete. In instances where the patient survives the early toxaemia, improvement gradually sets in. Upon operation we find only a portion of the pancreas destroyed. Suppuration may ensue early or aseptic hemorrhagic cysts may form. The third type is the so-called subacute and is more amenable to treatment. The destruction is usually limited to the head of the organ. The amount of hemorrhage being small.

A pancreatitis may arise from a biliary tract infection either from the ducts themselves or on account of the close relationship anatomically, i. e. from lymphatics which form a rich anastomosis in the retroperitoneal tissues about the pancreas. It may arise from a peptic ulcer, especially at the second portion of the duodenum, from a colitis, the appendix and the pelvic organs.

An acute intestinal obstruction when operated upon early, may reveal the obstruction to be caused by a fibrous band, a kinked bowel, by adhesion, strangulation of internal hernia, a sudden impaction of a gall stone in the small intestine, a sudden twist of the bowel or a sudden stricture of the small intestine. The normal color of the intestine is unchanged. When seen later the peritoneal coat has lost its luster, the wall is thinned out, agglutination of its surfaces with fluid exudate appears.

Some surgical considerations—The appendix is always to be removed except in those cases with an

abscess formation that with forcible attempts at removal, the line of resistance is broken and the infection spread. The two stage operation is therefore advisable; first, to drain the abscess, and second to remove the remnants at a later and safer time.

The same rule applies to a cholecystitis. In a cholecystitis with an accompanying abscess outside its walls here again it is more rational to drain the gall bladder and abscess and at a later and safer time remove the offending organ. Cases of cholangitis may demand a drainage over a long period of time.

In acute intestinal obstruction early operation is advisable and imperative.

In pancreatitis it is better to wait a short time before operating to allow the body to fortify itself.

The subacute cases are easily amendable to surgical treatment. Where abscess or cyst formation occurs the large abscesses and cysts give better results than the smaller multiple ones.

SOME REMARKS CONCERNING THE SMITH-INDIAN INTRA-OCULAR OPERATION FOR CATARACT.

BY FRANK ALLPORT, M. D.,

CHICAGO.

The most important (and perhaps I might also say, the most sensational), phase of the cataract subject before ophthalmologists at the present time, is what is popularly known as the "Smith-Indian" operation—as performed by Major Smith and modified by many surgeons of less experience. This procedure consists, as is well known, in the removal of the lens in its capsule after the method proposed by Major Smith, and when successful, produces brilliant and ideal results.

The only question for *us*, as American ophthalmologists, to decide is, whether this operation is the best one for *us* to perform. I will not attempt to speak for others (especially as the Smith enthusiasts seem quite capable of speaking for themselves), but as for me, I will say, that I do not feel justified in adopting this operation in my own practice. I am just an average operator—neither better, nor (I hope) worse than my neighbor—and I feel if I can get the average percentage of good results by safer methods for my patients, who come to me for vision, and not for experimental surgery, that it is my duty to give them the best that is in *me* and I am sure this would not be the case if I began doing the Smith operation. I am perfectly willing to acknowledge that Major Smith and a few other East Indian operators of enormous experience, who do many of these operations daily, can do them successfully and achieve a large majority of brilliant results. I concede this, although I contend that statistical results of *all* these operations might not be as convincing as the intra-capsular operators desire. These poor blind people make cataract pilgrimages to the Smith Shrine, are operated, and then return as quickly as possible to their distant native hills and are never seen or heard from again, thus rendering the collection of accurate ultimate statistics impossible. For this reason, we may never know what all the *end* results are of this much extolled surgical procedure, but for the sake of argument, let us admit, that they are all that Smith and his followers claim. There are still other phases of the controversy to settle. In the first place, I doubt very much if Major Smith himself could come to America and produce as good results as he does in India. Of course, this is merely an opinion, and it may be a wrong one, but I believe it is a rational opinion and would prove to be a true one. Smith's patients in India, are tractable, patient, obedient people, unpoisoned by stimulants and excessive and rich food. Quick healing and slight reaction should be the rule under these circumstances. Should Smith, however, come to America he would be confronted by an entirely different class of patients. He would operate on a large number of unmanageable, impatient, nervous, disobedient, opinionated people, accustomed to servility from others, whose bodies have grown fat, flabby and diseased by laziness, gluttony, drink, auto-intoxication, syphillis, etc., and with whom slow healing and considerable reaction may be reasonably expected. If this is true, then these operators of *less* experience than Smith will surely get even poorer results than he would. On account of his natural skill and immense and unprecedented experience, Smith has acquired a skill and dexterity, unequalled by any living man. He can do things no one else can do; he can meet emergencies better than any cataract operator in the world. The intra-capsular operation to him is mere child's play, but while this is an easy procedure for Smith—with his thousands of cases a

year—it is a difficult and extra-hazardous operation for such people, for instance, as the writer of this paper, who has never done to exceed fifty senile cataract operations in a year. What right then have I to desert a well-tried, conservative, almost invariable successful operation, which I can perform with comparative ease, in order to try an experimental, sensational, difficult and extra-hazardous surgical procedure, merely because Smith and a few of his followers do it and because some men are doing it in this country, and because it is spectacular. Its advocates will say, in refutation of these statements, that these are not the *real* reasons for their allegiance at all; that they operate on account of the clear pupil, the absence of lenticular and capsular remnants, the lack of iritis and the superior vision. This may be, and doubtless *is* true in the successful cases; but what of the unsuccessful cases where collapsed and ruined eyeballs follow in the wake of the ambitious, but perhaps unwise operator? *We do not hear so much of these cases.* "The greatest good to the greatest number" should be the motto of all cataract operators, and I am sure that this result cannot be attained in this country by using the Smith-Indian operation. Some intra-capsular operation may be, and I believe will be devised, that will be suitable for *average* operators, but the Smith-Indian operation is not the one. Some claim that this operation is not so difficult after all, but I am confident that only a few over-zealous desciples entertain such optimistic views. The fact is—it is a complicated, difficult and dangerous surgical procedure, except in the hands of a few men like Smith and other East Indian surgeons—and even their hands might lose their cunning unless they were kept in constant practice. Those enraptured and hysterical people who perform nervous stunts when Paderewski plays upon the piano can hardly conceive that his prodigious skill would quickly disappear unless he constantly practiced upon his chosen musical instrument. He himself has said, however, that if he did not practice for one week, his enemies quickly discovered his shortcomings. If he did not practice for two weeks, his friends shook their heads in consternation, and if he did not practice for three weeks, he himself knew that he was only a second rate pianist. And so I believe it is with the East Indian operation. I believe that those surgeons in East India, whose stock of cataracts seems to be inexhaustible, are warranted in performing this operation because they operate many times a day and acquire and maintain a special skill and dexterity, but I do not believe that men in this country, who only operate a few cases a year, should unnecessarily risk vision and the happiness of those patients, who confide themselves to their care, because they, for one reason or another, are determined to risk the Smith-Indian procedure. Those gentlemen who have acquired operative advantages over those who remained at home, by making enterprising journeys to the East Indian Fountain Head of Intra-Capsulology, and have acquired first hand knowledge on this subject, fortified by experimental operating on several hundred unfortunate blind East Indians, seem to have (at least for some time), regarded this operation as the only one to perform. Those operators, compelled to forego the advantages of this wonderful experience of East Indian post-graduate instruction, naturally sustained a sense of mortification and self-abasement when these travelers, one by one, returned with glowing accounts of the wonders of India. They were forced into a self-acknowledgment of primitive old-fashiondom and reminded one of the little poem in a New York paper after the unsuccessful campaign of Tom Platt, managed by Mr. Lemuel Eli Quigg:

"If I were Lemuel Eli Quigg,
Lem Eli Quigg,
Lem Eli Quigg,
If I were Lemuel Eli Quigg,
I'll tell you what I'd do:

I'd crawl into a woodchuck hole,
An auger hole,
A gimlet hole,
I'd crawl into a gimlet hole
And pull the hole in too."

But this burden of humility has somewhat lightened as time has progressed and it has been observed that those enthusiastic returning cataract pilgrims have mostly—one by one—begun by making various modifications of the Smith operation and its special instruments, and ended by using this operation only in "selected cases"—whatever that may mean. I suspect, however, it means that having once left the "Mysterious East", the personal magnetism of Smith and the fascinations of his surroundings, and once more returned to the

commonplacedness and sordidness of America, the inspiration of the Master has faded gradually away and they have been compelled to realize that *their* individual fields of activities lie, not in India (with its hordes of migrating, cast-off humanity, involving but little surgical responsibility, where eyes may be lost by the dozens without creating any particular disturbance in the ebb and flow of life's tide), but in America, with its distinctly different climate, population and environment, where eyes are eyes, and law is law, and where heavy burdens of responsibilities are loaded on surgeons' shoulders, and where a lost eye may be a very Ghost of Banquo in its power of disturbance and disquietude. Besides this—they have, I fancy, learned quite early that this is an operation requiring constant experience to maintain surgical dexterity and wisdom, and that whereas in India the supply of cataracts is more than equal to the demand, in America even a busy ophthalmologist may not operate perhaps more than fifty senile cataracts per annum. I think, therefore, that, rather than attempt this brilliant procedure, which I believe should only be used under favorable circumstances by exceptionally expert and experienced surgeons, that we might be better occupied in perfecting the quite satisfactory operation with which we are already familiar, and in reaching out along more conservative lines for the future intra-capsular operation.

MAKE OUR SODA FOUNTAINS SAFE FOR THIRSTY HUMANITY, PLEA OF ICE CREAM "SLAVE"

You might, sir, entitle this epistle "The Confessions of an Ice Cream Soda Slave" or "The Curse of Newspaper Reading." or both. I am, or was an ice cream soda slave. While my serfdom is a thing of the past, the craving is still as strong as ever, and the last few warm, luscious days of spring have been trying on the soul.

For years and years (how many I dare not say) I stepped up to the soda fountain and stood my ground with the best soda swiggler in the community. (Can anything be so satisfying as a chocolate ice cream soda on a blistering day?) I repeat, for years and years I was a slave to the habit. And nothing ever happened. Not even in the days when the more or less alert health departments did not require cream to be used in the manufacture of "ice cream" and a mere matter of artificial coloring only lent variety.

Last summer I swore off—I think that is the term, swore off. That is why I am writing this letter, following, after a fashion, the precepts of the psychoanalyst—you, Mr. Editor, being the psychoconfessor, if I may be pardoned for coining the term, while I, your correspondent, am the self-analyed subject. I hope I make myself clear.

One noon last summer while eating my lunch preparatory to sallying forth to top it off with a cool and bracing pineapple frappé, my eye rested on the page of the newspaper in which my repast had been wrapped. So does fate work. I brushed aside the bit of butter that had blotted out what seemed to be an interesting part of the article, and I read: "An examination under the microscope of one carelessly washed soda water glass revealed in the thick coating which covered it both inside and outside more than 20,000 human cells and bits of skin. Clinging to a single one of these cells there were counted 150 germs. The total germ population of the glass was estimated at 3,000,000, representing a dozen serious diseases."

Well, it was rather perturbing, but out I went for my daily treat. I got as far as the counter, and there I stopped. And I stood there as long as I could, watching the shifting mob, struggle to have the use of one of the free-for-all glasses in use. Wash the glasses? They received less than the so-called "lick and a promise." I wanted to shriek out and tell those innocent fools that their lips were associating with three million homeless germs, the forefathers of a dozen serious diseases.

I turned sadly away, and my happy nature became morbid. Life had lost one of its joys, and all because some sensational news gatherer had gotten a few scientific facts to show that the common soda water glass was a menace to health.

If this were so, if tuberculosis, diphtheria, whooping cough, even infantile paralysis, could be transmitted through the medium of the common soda water glass, why were they permitted to be used? Dr. Crumbine, of Kansas, who was the first health officer to take official action against the public drinking cup, began his crusade because a Kansas girl had contracted a disease through the use of a public drinking cup on a train. Yet there are more people using soda glasses in a day than would use a public drinking cup in months. And the opportunity for germs to cling to a sticky sirupy glass are far greater than those afforded by a glass or cup in which water is used.

Could the health authorities be blind to this alarming situation, I wondered? Railroads had been forced to provide individual drinking cups on trains and in stations and nearly every State has legislated against the public drinking cup.

Why should not soda fountain proprietors, who served all who demanded service regardless of race, creed or state of health, be compelled to protect their customers? What had Dr. Crumbine, of Kansas, done? What action had the New York health authorities taken? What of other States? If this condition were not overdrawn why was not something done?

Something was done! And that something was done by Uncle Sam. The soda fountain in or near the training camps were put under strictest regulations, and

strictest rules for sterilization of glasses were established, or, in lieu of sterilization, the provision of individual paper containers was made mandatory.

Now, sir, as I set forth in the beginning, you might have called this "The Confessions of an Ice Cream Soda Slave," I have purged my soul and feel better for it. It will not help me, I am afraid, to pass a soda fountain without a tremor, and it may cause some of your readers to feel as I do, which will be too bad in a way. Still there must be martyrs for any cause, and maybe we can borrow some wisdom from the barbarians of the West and make our soda fountains safe for thirsty humanity.

R. McN.

BOOKS RECEIVED

Infection and Resistance. By Hans Zinsser, Professor of Bacteriology at Columbia University. 585 pages, illustrated. Second edition. The MacMillan Company, New York, 1918. Price $4.25.

Reclaiming the Maimed—A Handbook of Physical Therapy. 128 pages, illustrated. The MacMillan Company, New York, 1918. Price $2.00.

The Medical Clinics of North America. Volume 1, Number 5 (The Chicago Number). Octavo of 241 pages, 35 illustrations. W. B. Saunders Company, Philadelphia and London, 1918. Published Bi-monthly. Price per year: Paper, $10.00; Cloth, $14.00.

Diabetic Manual. By Elliott P. Joslin, Assistant Professor of Medicine, Harvard Medical School. 187 pages, illustrated. Lea & Febiger, Philadelphia and New York. Price $1.75.

Oral Sepsis in its Relationship to Systemic Disease. By William W. Duke, M. D., Ph. B. 124 pages, 170 illustrations. C. V. Mosby Company, 1918. Price $2.50.

Interpretation of Dental and Maxillary Roentgenograms. By Robert H. Ivy, Major, M. R. C. 146 pages, 259 illustrations. C. V. Mosby Company, St. Louis, 1918. Price $2.50.

Emergencies of a General Practice. By Nathan Clark Morse, A. B., M. D., F. A. C. S. 449 pages, 251 illustrations. C. V. Mosby Company, St. Louis, 1918. Price $4.50.

Tumors of the Nervus Acusticus and the Syndrome of the Cerebellopontile Angle. By Harvey Cushing, M. D. Professor of Surgery at Harvard University. Surgeon-in-Chief to the Peter Bent Brigham Hospital. Formerly Associate Professor of Surgery at the John Hopkins University. Director of the United States Army Base Hospital No. 5. Illustrated. W. B. Saunders Company, Philadelphia and London. 1917. Price, Cloth, $5.00 net.

A Text-Book of the Practice of Medicine. By James M. Anders, M. D., Ph. D., LL. D. Professor of Medicine, Medico-Chirurgical College Graduate School, University of Pennsylvania; Consulting Physician to the Jewish Hospital and to the Widener Home for Crippled Children; Officer de l'Instruction Publique, etc. Thirteenth Edition—with the assistance of John H. Musser, Jr., B. S., M. D. Associate in Medicine, University of Pennsylvania; Physician to the Philadelphia General Hospital; Physician in Charge of the Medical Dispensary, University of Pennsylvania; Assistant Physician and Chief of Dispensary, Presbyterian Hospital. Illustrated. W. B. Saunders Company, Philadelphia and London, 1917. Price, Cloth, $6.00 net; Half Morocco, $7.50 net.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1917. Cloth. Price, postpaid, 50 cents. Pp. 169. Chicago: American Medical Association, 1918.

This volume contains the reports of the Council which were adopted and authorized for publication during 1917. These Council Reports discuss the articles which were examined and found to be in conflict with the rules for admission to New and Non-official Remedies. It also explains why certain preparations, included in the last edition of New and Non-official Remedies, have been omitted from the present 1918 edition. Those who wish to be informed in regard to proprietary remedies should have the annual Council Reports in addition to New and Non-official Remedies.

New and Nonofficial Remedies, 1918, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1918. Cloth. Price, postpaid, $1. Pp. 452 + 26. Chicago: American Medical Association, 1918.

This book lists and describes the proprietary remedies which the council on Pharmacy and Chemistry has examined and found to conform to its rules for acceptance and publication in New and Nonofficial Remedies. It also describes the newer nonproprietary and unofficial medicaments which, in the opinion of the Council, give promise of having some real therapeutic value. The description of each article aims to give a statement of its pharmacologic actions, its therapeutic uses, with dosage, the physical and chemical properties, and tests for controlling its identity and purity. Articles of similar composition are grouped together. In most cases each group is preceded by a general article which compares the composition and actions of the members of a group with each other and with the established drugs they are intended to supplant. Those who desire trustworthy information in regard to the newer drugs should have a copy of this annual.

ALBERT WILLIAM MYERS, M. D.

1872—1918.

The recording of the lamentably premature death of Albert William Myers, editor of this Journal from January, 1910, to January, 1916, is one of the most painful duties the Managing Editor could be called upon to perform. No one could enjoy the privilege of a community of interest with Doctor Myers for any length of time without being impressed with his high ideals with reference to all of the different relations of life and inspired by his scientific, literary and professional attainments. His unselfishness and his devotion to the cause of modern medicine and to the welfare of society at large were manifested by the self-sacrificing and efficient service which he rendered as editor of this publication for a period of six years and by his labors in the several medical and medicosociologic societies in which he took an active interest and to which he rendered such constructive and far-reaching service. His position in these societies cannot be readily filled. His innate patriotism was revealed by the keen disappointment which he manifested when apprised that he was, for physical reasons, rejected for service with Milwaukee's Base Hospital Unit. His conscientiousness, his unusual ability, his gentleness, his graciousness and his genuine cordiality early ripened the appreciation and admiration of his friends, colleagues and patients into an affection, which the lapse of time will not efface. Those indebted to his many virtues, graces and professional ministrations were so numerous that truly may it be said: "If everyone for whom he did some kindly act were to place a petal upon his grave today, he would sleep tonight beneath an avalanche of flowers."

Resolutions adopted by the Milwaukee Medical Society upon the death of A. W. Myers

Albert William Myers, a long time member of the Milwaukee Medical Society, died of pneumonia at his home on July second, 1918.

In his passing the Profession of Medicine has lost a student, an investigator, a contributor to its science and a distinguished pediatrician whose high qualifications were widely recognized.

The Medical Societies to which he belonged have lost an active, consistent member who gave generously of his time and who contributed freely but discriminatingly from his wide and well considered experiences.

The Medical Journals have lost a worker from their field whose services have been valuable both as an editor and a writer.

The Community in which he lived has lost a courageous, cultured, Christian gentleman, who skillfully and untiringly served the rich and the poor from motives invariably unselfish.

Those who knew him intimately have lost a friend whose constant loyalty, quick sympathy, wholesome geniality, and companionship have left sad hearts but happy memories.

Therefore, in noting the death of Albert William Myers the members of the Milwaukee Medical Society resolve to record upon their minutes for permanent record these facts of his life, and to send copies of this resolution to his bereaved wife and relatives in sympathy which is deep and which they believe to be understanding because they knew him.

Arthur T. Holbrook,
Henry V. Ogden,
Arthur J. Patek,
Committee.

Resolutions adopted by The Medical Society of Milwaukee County upon the death of Dr. Albert William Myers

Formal resolutions can not convey the deep sense of loss and the sorrow with which the Medical Society of Milwaukee County records the death of one of its most valued members, Dr. Albert William Myers. Taken from us at the height of a successful professional career which brought him large opportunity for service and in which there was much of promise still unfulfilled, his death was a distinct shock to all who knew and, in the knowing, honored and loved him.

To all his various tasks he brought a quiet and conservative, but unconquerable optimism and idealism. In the interests of his patients, rich, poor and middle-class, he labored unselfishly and with endless patience, skill and fidelity. As a clinician, an editor of the Wisconsin Medical Journal, a medical librarian, and a member of this and various medical societies and of hospital staffs, he was, and by the abiding impress of his work still continues to be, a leader among us.

We who knew him as friend and as physician mourn the personal loss that has come to us. We shall miss his comradeship, the inspiration of his presence and his counsel, the ministrations of his healing skill. They have been taken from us and we speak of Dr. Myers as dead; but that is only partial truth. Much that was finest in his work lives on, for his greatest, his most vital service to the community lay in his constructive contributions to the advancement of preventive medicine. Through his work on the staff of the Children's Hospital and as advisor to the Infant Welfare Division of the Milwaukee Health Department, he has aided in setting in motion forces which will continue everlastingly to save countless numbers of human lives.

In this knowledge lies the truest tribute to Dr. Myers, a tribute far more eloquent than mere words can express.

H. E. Dearholt,
A. J. Patek,
A. L. Kastner,
Committee.

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L. M. WARFIELD, M. D., Editor
79 Wisconsin Street, Milwaukee

J. P. McMAHON, M. D., Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:
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EDITORIALS

FORMER EDITOR DIES.

AT the Zenith of his activity, the goal of his endeavor attained, his services to the community rewarded by generous appreciation, and enjoying the fullest confidence of his fellow physicians, Dr. Albert William Myers was called from this earth on July 2nd after an illness of but a few days. Death was due to pneumonia, complicated by a cardiac affection of several years' duration.

Dr. Myers was born in Dixon, Ill., in 1872. After completing a high school course at Ishpeming, Mich., he was engaged in the banking business for a period of five years, after which he entered the Medical Department of the University of Pennsylvania, where he graduated in 1896. After serving interneships at the Episcopal and Philadelphia Children's Hospitals, he entered upon private practice in Milwaukee in 1900. He soon evinced a leaning toward pediatrics, gradually devoting more and more of his time to this specialty, and during the past few years limited his practice to this branch of medicine. Through his active association with the Milwaukee Children's and the Milwaukee Infants' Hospitals and through his teaching position at Marquette University Medical School, as well as through an extensive private and consulting practice, he had established himself as the foremost specialist in his branch in the city and state. His activity in local, state and national medical bodies, gave him scope for the exhibition of his unusual ability. His virility as a writer on medical subjects was exhibited during his editorship of The Wisconsin Medical Journal, which position he held for a period of six years.

One could continue many encomiums upon Dr. Myers' professional career, but his engaging personality deserve attention to an equal degree. He possessed an unusually winning nature; he was pleasing in conversation; and he was endowed with those charming qualities that made him the most companionable of men.

Those who—having known Dr. Myers intimately—had learned to appreciate his sterling worth, know well that their community can ill afford to lose a man of his exceptional type; the niche he had carved out for himself cannot be easily filled by another. With his death there is lost to the city of Milwaukee one whose counsel, because of his mature judgment and sane visions, was soon to be called upon in matters of much moment to the further development of infants' welfare and diseases of children in this community.

The friends and associates of many years deeply mourn Dr. Myers' death, for with his passing away there goes from their midst a beautiful character, a beloved companion, a noble physician.

THE A. M. A. MEETING.

THE recent meeting in Chicago was given a decided military aspect by the number of Medical Officers present. The civilians were there too, but they were not much in evidence on the program or in the discussions. The program seemed good in every Section, but the writer

can speak for only one, the Section on Medicine. The Symposium on Pneumonia was a most interesting meeting. Such an opportunity to study large series of cases under complete control had never before been granted to the medical men of this country. They did not let the rare opportunity slip by. Pneumonia held the stage in the present mobilization of our forces as typhoid held it in the brief Spanish-American War. The epidemic which began in all the camps about the first of the year was everywhere most virulent and was complicated with an unusual number of empyemas. These cases were early seen to be different from the ordinary familiar pneumonias of civil practice. They did not begin with a chill and pain and high fever. On the contrary, they often began with what seemed to be just a mild cold, sore-throat, or bronchitis. Some cases developed pneumonia so gradually that it was difficult to say when the process began in the lungs. In other cases the patient was violently septic from the beginning and seemed to be overwhelmed by toxins.

Large effusions would develop over night and were most difficult to diagnose so that recourse was had, whenever fluid was suspected, to the aspirating needle. The organism responsible for the disease was found to be the Streptococcus hemolyticus. This organism was found in pure culture in the fluid (pleural), in the lungs, in the heart's blood at autopsy. It was also recovered often from throat and sputum in practically pure culture. It was found that many carriers were in the hospital wards and that those coming to a ward where there were many carriers soon became highly infected and many developed pneumonia. The most successful prophylactic against the spread of the infection was the use of a face mask made out of gauze. This was worn by all patients, nurses, hospital corps men and ward surgeons. The patients were also isolated in cubicles formed out of sheets. When these precautions were taken some were able to see an appreciable decrease in the number of cases infected with the hemolytic streptococcus.

There was no treatment which seemed to do much good when the case was virulent. Some men began early in the disease to give relatively large doses of digitalis. This is contrary to all the best practice in the cases of pneumococcus pneumonia. When fluid collected in the pleural cavity, it was found best not to operate at once but to aspirate again and again until the fluid became fairly thick. The patient in the meantime had recovered from the shock produced by the intense sepsis. Operation then with resection of a rib, drainage into a bottle by a long tube with the tube in the pleura sealed in the incision, irrigation with Carrel-Dakin solution, gave the greatest number of recoveries.

A point to which all the speakers called attention was the uncertainty of the physical signs when fluid was present. All the old, well-known signs taught in the books were useless as guides in diagnosis.

No one seemed to wish to venture an opinion on the origin of the widespread epidemic. It was not the same as the measles pneumonia. It did not follow the curve of measles, although measles was the cause of the more easily susceptible condition of some soldiers. The infections of the upper respiratory tract were either predisposing factors or were themselves, as was proved, due to the streptococcus.

This series of papers will be published, we hope shortly.

There were other papers of interest in the Section and an intensely interesting series of papers on Reconstruction and Rehabilitation of Disabled and Crippled Soldiers. We earnestly urge all doctors to familiarize themselves with this great movement. There is propaganda to be spread broadcast in the education of the public and the employers of labor to the end that the stigma of uselessness be forever cast forth from these people. When one hears of the work which the re-educated cripple is capable of doing and can do, it puts to the blush the work of many whole people. We need help in this campaign. Our cripples and mutilated men will soon, we are sorry to say, be coming back from the hell which German has given to the world. It behooves us all over this land to be prepared to give them help. Not charity, not gifts of money, but real understanding sympathy and real assistance so that they may be self-supporting. This is a great work in which all can help .

L. M. W.

SURGEON-GENERAL GORGAS IS SIXTY-THREE YEARS YOUNG.

THE *Washington Post* on May 7 is responsible for the statement that Surgeon-General Gorgas will reach the retiring age of sixty-four on October 3, 1918. Of course this does not mean that General Gorgas will be retired in October, because no one would consider retiring a man

who every day is demonstrating his youth and efficiency in a position of such great responsibility as that of Surgeon-General of the United States Army during the greatest war in history.

Those who are in a position to know, regard General Gorgas as second in efficiency only to President Wilson; and they marvel at the work he has accomplished in the past year. Only a young man in vigorous health could have lived through what the General has done since the War began. Office hours begin in his office at 9 o'clock, but General Gorgas is there by 8 or 8:30, and he is one of the last to leave in the afternoon. He walks to and from his work, more than a mile, every day, and he climbs up and down the seven flights of stairs in the Mills Building several times a day, because he likes the exercise and sometimes can not wait for an elevator.

Years ago General Gorgas demonstrated that the white man can live, thrive and accomplish as much in the tropics as in colder climates, if malaria and other tropical diseases have been eradicated. Now some are believing that he discovered somewhere on the Isthmus of Panama the fountain of youth that Ponce de Leon sought in vain in the sixteenth century. At any rate, it is believed in Washington, too, that the two best places of residence in the world for developing youth and efficiency are Princeton and Panama.

It is just possible that there exists in Jersey and Panama a variety of mosquito that transmits to those whom it bites the germs of youth and efficiency. This theory, however, does not seem tenable, because the French were bitten by mosquitoes in Panama and died by the thousands, and some are said to have been bitten by the Jersey mosquitoes, and all the inhabitants of New Jersey can not be considered presidential timber.

President Wilson is somewhat younger in years than General Gorgas, and since he has one of the best doctors in the country to see him every day, to keep him well, he may be expected to continue his wonderful degree of efficiency for many years. General Gorgas is his own doctor and he is engaged in the small undertaking of keeping a million and a half boys and young men from catching measles, pneumonia and some diseases that do not affect the respiratory organs, that afflict those who have not learned how to take care of themselves,—and he is doing both jobs better than any man befor him ever did. If one knows of the regular life and simple and abstemious habits of General Gorgas he can understand how at sixty-three he is younger than many men at forty. If all the soldiers lived the hygienic life that he follows, the Army sickness and death rate would be negligible, though it should not be forgotten that the morbidity and mortality rates among our troops are less than half those in the Spanish-American War, and are lower than those of any other army that was ever gotten together.

Of course no one has considered it possible for General Gorgas to be retired during this War. Millions of mothers and fathers and other relatives and friends of our soldiers thank God every day that General Gorgas is directing the army of doctors who are fighting diseases that are as dangerous and that are as insiduous enemies to mankind as the Huns. They feel comforted every day on realizing that Gorgas is safeguarding the health and lives of their boys.

Aside from the fact that there is no one who could so ably take the place of General Gorgas as Surgeon-General, the United States and the world owe him such a debt of gratitude that he could not be retired until his labors during the present War have been completed. His conquests over disease have been more brilliant and epoch-making than those of any general who has fought battles against man. Gorgas has brought health and happiness to millions, while wars against man have made countless thousands mourn.

The Gorgas in the Surgeon-General's office at Washington today is the same quiet, smiling, genial man who eradicated yellow fever from Havana for the first time in centuries. He is the same efficient genius in organization, whose achievement in the sanitation of the Canal Zone, President Taft said, "made possible the completion of the greatest industrial undertaking in the history of the world." He is the same Gorgas, but with greater experience, whom the British Government sent for to go to South Africa to study conditions and advise methods for preventing pneumonia that was killing thousands of miners in the Rand and in Rhodesia. All these tasks which he accomplished prepared him for the great work in which he is now engaged; and history does not record anything more remarkable than the training, in less than a year, of the great army of doctors, nurses and hospital attendants who now protect and care for our sick and wounded soldiers in this country and France.

The wisest, the most considerate man in the world appoints the next Surgeon-General of the United States Army; and since President Wilson holds justice and efficiency in such high esteem, there can be no doubt of the reappointment of Surgeon-General Gorgas when his term expires, or when he comes to the age of retirement. If the President has not the legal right to appoint a retired officer as Surgeon-General, Congress will enact a law giving him that privilege. Our country and the world need General Gorgas too much for his retirement to be considered until we and our Allies have conquered the Huns.—*Southern Medical Journal.*

THE $333,333.33 FOR MARQUETTE MEDICAL SCHOOL.

ON July 22nd, 1918, a drive will be begun in the city of Milwaukee, and throughout the State of Wisconsin, for the purpose of raising the sum of $666,666.66 in money or pledges of money, in order that the Marquette Medical School may be able to obtain the $333,333.33 that is offered it, out of the Carnegie fund; this donation being contingent upon the raising by the school and its friends of two-thirds of a million dollars; Mr. Carnegie giving the other one-third.

These facts are brought to the attention of the members of the Medical profession, throughout the State, in order that every man of its membership may be reminded of his manifest duty to his profession and the commonwealth, in that he shall make every effort in his power, and exert every influence that he is capable of, to the end, that this sum of two-thirds of a million dollars may be obtained, that the one-third of a million dollars may find its resting place within the State, and that, the total sum shall be utilized for the maintenance of the one first class medical school now giving a full class A course in Medicine within the boundaries of the State of Wisconsin.

This million dollars when obtained will not be administered by any sect or society for its benefit. It will be under the control of a board of thirteen trustees, composed of three members of the clergy, and ten representative business men and physicians, and the income from the fund will be used solely and only for the support of the Medical School, and of no other department of Marquette University.

We do not need to call the attention of the Medical profession to the desirability of the existence of a Class A medical school in the State, or particularly to the activities of the men who have placed this school in that catagory. In support of their efforts, at this time when the sacrifices they have made to the end that this school might become a credit to the State and country, cry aloud for our recognition, let us as a body join heartily in furthering the cause of better medical education, by the exercise of every effort within our power, to assure the success of this drive for two-thirds of a million dollars.

HOLD YOUR LIBERTY BONDS!

THE American who buys a Liberty Bond and forthwith sells it has performed only half a service for his country. To buy bonds and then sell them immediately tends to make the war burden of the country heavier instead of lighter, as it decreases the market value of the bonds.

Liberty Bonds are the safest and soundest and one of the best investments in the world. To sell them unless imperatively required is not good business, is not good Americanism.

SOLDIER AND SAILOR INSURANCE.

IN all of our war measures and activities there is nothing wiser and better and fraught with more good to our fighting men and the Nation than our soldier and sailor insurance.

That the members of the military and naval forces of the United States for whose benefit the insurance was established, are availing themselves of it is something that all good Americans will rejoice at.

More than 2,000,000 members of America's fighting forces are now insured by the Government for more than sixteen and a half billion dollars by the United States Government. Up to the close of business Monday night, May 13, 2,029,886 insurance applications, aggregating $16,663,514,000, had been received by the Military and Naval Division of the Bureau of War Risk Insurance. The average amount of insurance applied for is $8,209, the maximum permitted by law being $10,000.

Approximately 11,000 applications for Government insurance are being received daily. In the

last two weeks $1,000,000,000 of insurance was written on the lives of soldiers and sailors. This indicates that the new men joining the colors are taking out Government insurance.

Men are being urged to insure immediately upon enlistment, inasmuch as application must be made within 120 days after joining the service.

H. R. 12177.

TO conserve and increase the industrial man power of the United States; to increase the efficiency of the military and naval forces thereof; enlarging the powers of the Public Health Service by creating and establishing a Division of Venereal Diseases therein; providing for the punishment of immoral persons afflicted with venereal disease who go or attempt to go from one political division into another, and persons who assist or connive at the same; establishing internment hospitals; authorizing the Secretary of the Treasury to establish all needful rules and regulations relating to the subject matter of this Act; and authorizing an appropriation therefor.

The above bill has been introduced into the House of Representatives by Hon. John F. Miller of Washington. It is worthy of attention and support.

MEDICAL MOBILIZATION AND THE WAR

OGLETHORPE WILL BE GREATEST MEDICAL CAMP IN THE WORLD.

Camp Greenleaf, Ft. Oglethorpe, is destined to be the great army medical university of the United States, according to a recent speech of Col. E. L. Munson in command there, at a banquet before leading Chattanooga men. With its gradual absorption of the only other medical training school in the United States—Fort Riley—it will be made a permanent medical post. In selecting it as the site of this important medical seat of learning, it logically recommended itself for the purpose. It is the center of a circle of twelve great army camps with a population of 240,000. Climatic conditions are excellent and the geographical situation fine. It was also found that it was as cheap to move troops through Chattanooga from the west and northwest as through any point east of Chicago.

Col. Munson stated that all the energies of the war department in creating this medical branch of the armed forces will be confined to Camp Greenleaf. Many base hospitals, hospital trains, ambulance corps, etc. Divisions with a personnel of 200 enlisted men and 37 officers each will be sent there.

He stated that the class of medical soldiers coming there represented the highest types in the country. It is intended to broaden the medical profession, and lift it to a higher plane of efficiency.

THE CHICAGO MEETING ON SELECTIVE SERVICE REGULATIONS.

On Thursday, June 13th, at 2 P. M., a meeting of the physicians especially interested in the work of the medical profession in relation to the Selective Service was held at the Studebaker Theater, Chicago.

The chairman of the meeting was Major Hubert Work, Medical Aide to the Provost Marshal General. Discussion of the work was made by Major Work, Colonel Frank Billings, Mr. Graham Taylor, Lieut. Colonel James Phalen, Dr. James B. Herrick and Lieut. Colonel J. S. Easby-Smith, Washington, representing Provost Marshal General Crowder.

The meeting was continued on Friday, June 14th. Colonel Easby-Smith presided and the time was given over to informal discussion. In the afternoon Colonel Easby-Smith met with the Medical Aides to the Governors at the American Medical Association headquarters on North Dearborn street.

THE SELECTIVE SERVICE REGULATIONS.

Meetings are being held throughout the state by Lieut. Rock Sleyster, M. R. C., Medical Aide to the Governor, for the discussion of medical examinations under the selective service law. This is part of a general plan being followed throughout the United States. The importance of these meetings to physicians will be appreciated when it is realized that there are 156 district boards, 5,643 local boards and 1,320 medical advisory boards in the United States. It is estimated that there are some fifteen thousand physicians connected with the local and district boards. This estimate includes not only the medical boards but also the medical consultants and medical assistants utilized by the medical men on the boards. The number of members of advisory boards is approximately 9,500, making a total of between 24,000 and 25,000 physicians in this country who are connected with the examination of registrants.

The new "standards of physical examination governing the entrance to all branches of the Army of the United States for the use of the Regular Army, National Army, National Guard, Medical Reserve Corps, Recruiting officers of the United States Army and of local boards and

medical advisory boards under the Selective Service regulations" is now available. This excellent manual represents a text on physical examinations and a guide to the important regulations concerning physical examinations.

STANDARDS OF PHYSICAL EXAMINATIONS.

SOME IMPORTANT CHANGES.

Members of Medical Advisory Boards, physicians members of local Boards and examining physicians will shortly be engaged in making physical examinations under the new draft and in passing on the reclassification of registrants rejected or discharged from military camps or stations.

A careful study of the new standards of physical examinations, form 75, is absolutely necessary. The following are some of the changes which will be found and which should receive their particular attention.

MARKED CHANGES.

Eye. Blind in one eye or loss of one eye but with normal vision in the other without glasses—now placed in group C.

Ear. Registrants in whom otoscopic examination detects a perforation but with no discharge, formerly accepted, are now placed in group C.

Registrants with loss of one or both external ears, formerly accepted if hearing was within standard, are now placed in group C.

Extremities—Hand. Registrants with loss of left thumb, formerly placed in group C, are now accepted for general military service, as are stiff fingers of a degree not to interfere with function. Loss of both thumbs or of more than two entire fingers on one hand under the new regulations requires unconditional rejection.

Foot. Registrants presenting the defects described under t, u, v, w, x, y, z, aa, bb, cc, dd (page 23) are now unconditionally rejected for all military service.

In considering cases coming within the above, the examiner will read carefully paragraph 77 (E) and paragraphs 79 and 80.

Knee Joint. Internal derangements due to loose bodies and dislocation of semi-lunar cartilages are now rejected.

Varicose Veins. Excessive varicose veins are now cause for rejection.

Height, Weight and Chest Measurement. Reject, now, registrants above 78 inches or less than 63 inches in height, and those who weigh less than 116 pounds.

Registrants above 78 inches in height, those who are obese, whose chest mobility is low, and those whose weight is less than 116 pounds and apparently due to recent illness, employment or environment, should be referred to Medical Advisory Boards for study.

Abdomen—Hernia. All hernias except inoperable hernias are now to be placed in group B.

Neck. Registrants with *active tuberculous* glands are rejected.

Genito Urinary Diseases and Venereal Diseases. Registrants with absence of one or both testicles due to removal or atrophy will now be accepted for general military service.

Registrants with undescended testicle which lies within the abdominal cavity will be accepted. Undescended testes which lie within the inguinal canal is cause for rejection.

Varicocele and Hydrocele are not causes for rejection and accepted for general military service unless extremely large when they are classed in group B.

CLASS ONE.

That the order of Provost Marshal General Crowder to Gov. Philipp and to all governors asking for a reclassification and a re-checking of the men under the draft with a view to increasing the number in class one will have little effect in Wisconsin is the opinion of the draft officials.

A telegram received by Gov. Philipp indicates that the average of class one men throughout the United States is 28.7 per cent of all men registered. The spirit of the telegram is that all registration should be brought up to that average. Weeks ago under the direction of Gov. Philipp the state of Wisconsin conducted an investigation to see if men belonging to class one had not been placed in deferred classification. A report of this matter has recently been filed with Provost Marshall General Crowder.

An investigation shows that in the five districts of the state an average of class one is 26.7. The averages for each district is as follows:

Western district No. 1—24 per cent.
Western district No. 2—32 per cent.
Eastern district No. 1—23 per cent.
Eastern district No. 2—29 per cent.
Eastern district No. 3—29 per cent.

The two districts in the state to fall below the average were Western district No. 1 which contains a large agricultural population of the state and the Eastern district No. 1, which includes Milwaukee, where exemptions were granted because of industrial reasons.

These investigations were conducted by Maj. E. A. Fitzpatrick, J. A. Blackshare, Madison; L. H. Rohr, Racine, and Dr. Rock Sleyster, Waupun. As a result of this investigation there was a re-examination of men given deferred classification on account of aged parents, physical defects and public official class.

Maj. Fitzpatrick said today that out of the 104 local boards in the state, probably about fifteen fell below the government average of 28.7. However, there will be a further investigation.

COURSE FOR HEALTH INSTRUCTORS.

During the last few months, as a result of the organized effort which is being made to meet the nursing needs of the state in the war emergency, there have come to the Wisconsin Anti-Tuberculosis association many requests for a material extension of its training courses for public health work. To those in close touch with the progress of health work, the need for a rapidly increasing number of trained workers had been manifest before the war for even without the competition of army needs the number of specially trained public health nurses has never equalled the demand, in spite of our many general and very personal efforts to interest private duty nurses in taking up public health work. The public, awakened by war conditions, is now realizing this situation and frantic appeals to "do something" have come to us from many communities whose public health nurses have responded to the urgent call of the army and who are facing the possibility of being unable to secure nurses to take their places.

In response to these appeals the Wisconsin Anti-Tuberculosis association has pledged itself to use every effort within its power to enlarge the scope of its training courses. To this end it is supplementing its short summer course and its two four months training courses for nurses with a ten months' course for the training of teachers, normal school and college graduates, to serve as health instructors and supervisors. This new course which will be the first of its kind in the United States, does not in any way take the place of the courses for graduate and senior pupil nurses. Its purpose is to make available a new type of trained worker in the public health field who will work in co-operation with and not in opposition to the public health nurses. This will make it possible to utilize the public health nurses more exclusively in those positions of responsibility where nursing training is an absolute requisite than is possible under the present system when in many instances the nurse is the only trained social worker in the community. It is felt that much of the health educational work, especially in the schools, could be done by teachers, naturally qualified for the work and fitted for it by specialized training. This is the purpose of the new course, a more extended notice of which appears in the Crusader, copies of which are being sent you under separate cover.

At the same time this new course will not in any way minimize the need for an aggressive campaign to increase the number of public health nurses available for service in the state during the coming year. There are several counties that will undoubtedly vote next fall to employ county nurses if they can be assured that they have a reasonable chance of securing the nurse after the appropriation is passed. We need scarcely call your attention to the fact that war conditions will increase the need for nurses in the industrial field and that one of the direct results of the Children Year's campaign will be a demand for more nurses to supervise the follow-up work. Recruits for these positions must come from the ranks of the private duty and the retired nurses who are willing to return to service. The Wisconsin Anti-Tuberculosis association will bend every energy to providing the training if the nursing profession will furnish the student material.

Proceeding on the assumption that the nurses within the state will be responsive to this call to service, the association is organizing its forces to make the four months course which will open in September one closely related to the state's immediate needs. Special emphasis will be laid on rural nursing with a view to fitting a number of the students for positions as county nurses. The second course, according to present plans, will begin in February, thus making two classes of graduates from the nurses' course and one from the Teacher's training course available for public health work within the year. These are in addition to the eleven nurses who now are taking the short summer course. Dr. E. V. Brumbaugh will have general supervision of all the courses but the personal direction of the nurses' classes will be, as in the past, in charge of the association's supervising nurse.

In notifying you of the association's plans to meet the demands of the times as far as it is within the power of its resources to do so, we bespeak your cordial interest and co-operation. We should welcome an official approval of these plans and also any suggestions which you believe to be helpful and timely.

THE ARMY SCHOOL OF NURSING ANNOUNCEMENT, 1918-1919.

GENERAL STATEMENT.

The Army School of Nursing established by the Surgeon General under the Medical Department of the Army, offers to women desiring to care for the sick and wounded soldiers a course leading to a diploma in nursing, should the military hospitals continue in operation for the full period of the course. Should the cessation of hostilities occur before the completion of this period, credit for all branches of nursing completed will be given in a certificate by the Army School of Nursing, which certificate will entitle the holder to recognition by such civil hospital training school as may subsequently accept her as a student. The school is located in the Surgeon General's Office, Washington, D. C.; the training will be given in the various military hospitals and through such affiliations as may be required to complete the course.

The military hospitals will provide experience in surgical nursing, including orthopedic, eye, ear, nose and throat; medical, including communicable, nervous and mental diseases. Experience in the diseases of children, gynecology, obstetrics, and public health nursing will be provided through affiliations in the second or third year of the course.

Lectures, recitations and laboratory work will be given in the required subjects, each hospital assigned as a training camp having its director, staff of lecturers, instructors and supervisors, and teaching equipment.

The course extends over a period of three years. Credit

of nine months, or approximately an academic year will be given to graduates of accredited colleges. Credit of three or more months will also be given to students who have had two or more years of college or in approved technical schools that have included prescribed courses in the sciences.

The three years will be divided into a preliminary term of four months which will also be a probationary period, a junior year of eight months, an intermediate year of twelve months and a senior year of twelve months. Out of this period a vacation of one month for each year in the school will be granted.

The hours of duty on the ward will be arranged in accordance with the required class work. During the preliminary course they will not exceed six hours daily and thereafter eight hours.

ADMISSION.

Candidates desiring to be considered for admission to the Army School of Nursing should make application in person or in writing, or through the Division Directors of the Bureau of Nursing of the American Red Cross, to the Surgeon General of the Army.

Special consideration will be given to those candidates who have taken the course in Elementary Hygiene and Home Care of the Sick under the auspices of the American Red Cross, providing they meet the requirements for admission to the Army School of Nursing, and such candidates are advised to apply for the application blanks to the division directors of the Bureau of Nursing or the instructors of the course in Elementary Hygiene and Home Care of the Sick.

Candidates will be admitted in accordance with the needs of the service, the first class entering on or about July 1, 1918.

They will be assigned to the various training camps and to the services provided through affiliations as may be determined by the Dean of the Army School of Nursing.

To be eligible to the Army School of Nursing, candidates must be between 21 and 35 years of age, in good physical condition and of good moral character. They must be graduates of recognized high schools or present evidence of an educational equivalent.

EXPENSES.

No tuition fee is required. The students will be provided with board, lodging and laundry through the period of the course, and with the required text books. They will be required to provide themselves with indoor uniforms for the preliminary course, and upon its successful completion, with an outdoor uniform and such additional indoor uniforms as are required during their residence in the school. A monthly allowance of fifteen dollars ($15.00) to meet these and other school expenses will be provided, except for the period of affiliation.

Full instructions concerning the uniform and general equipment for service in the military hospitals will be sent to each applicant upon the acceptance of her application.

ILLNESS.

A student is entitled to medical treatment while on duty. This will ordinarily be furnished at the hospital to which she is assigned; but in proper cases the Surgeon General may order a student's transfer to and treatment in, some other Army hospital. When the treatment required by a student on duty cannot otherwise be had, the necessary civilian service may be employed as authorized by Army Regulations. Bills contracted by a student for medical care while on leave or absent without leave cannot be allowed. Time lost by illness if exceeding two weeks in any one year must be made up.

EXAMINATIONS.

Examinations, both practical and theoretical, will be held at the completion of the preliminary term, at the end of each course of lectures, and at the completion of each year. The passing of the examination combined with the general record—which includes practical work, conduct and general class work—will determine the advancement of the student into a higher class.

The decision of the propriety of retaining the student in the school upon the completion of the probationary period will be made by the Dean upon the recommendation of the Director under whom the student has taken the course. The connection between the student and the school may be severed by either side at any time during the period of training if so desired. Students who have of their own volition severed their connections with the school will not be reinstated unless the reasons submitted at the time of their withdrawal be considered adequate. Discipline shall accord with that governing the members of the Army Nurse Corps.

GRADUATION.

Candidates for graduation must have completed the prescribed course of three years—or such period as may be necessary to supplement the credits allowed—and passed their final examination.

Upon the completion of the course the students will become members of the regular Army Nurse Corps in the order of the vacancies, or should there be no vacancies, they would be placed on the list for appointment as vacancies occur.

They will be eligible for registration in any state except that those students to whom credit for collegiate or technical work shall have been given, will not be eligible for registration in those states requiring the full three years course in a hospital. They will also be eligible for membership in the American Nurses' Association, the National Organization for Public Health Nursing, enrollment in the nursing service of the American Red Cross and for advanced courses in the teaching, administrative and public health nursing fields.

All communications should be addressed to The Army School of Nursing, The Surgeon General's Office, Washington, D. C.

Applications through the Division Directors of the Bureau of Nursing of the American Red Cross should be addressed as follows:

New England Division, 755 Boylston St., Boston, Mass.

Atlantic Division, 44 East 23rd St., New York City.

Pennsylvania Division, 1601 Walnut St., Philadelphia, Pa.

Potomac Division, 930 16th St., N. W., Washington, D. C.

Southern Division, 424 Healy Bldg., Atlanta, Ga.

Lake Division, 929 Garfield Bldg., Cleveland, Ohio.

Gulf Division, Post Office Bldg., New Orleans, La.

Northern Division, 202 Essex Bldg., Minneapolis, Minn.

Central Division, 180 N. Wabash Ave., Chicago, Ill.

Southwestern Division, 1617 Ry. Exchange, St. Louis, Mo.

Mountain Division, 14th and Welton Sts., Denver, Colo.

Northwestern Division, White Bldg., Seattle, Wash.

Pacific Division, 942 Market St., San Francisco, Cal.

SYNOPSIS OF THE COURSE OF STUDY.

The program of instruction is based on the standard curriculum for schools of nursing issued by the National League of Nursing Education in 1918.

The time allotted to the various subjects will be divided between lectures and demonstrations by members of the medical staff or special lectures; and classes, quizzes and laboratory work under qualified nurses and other instructors.

The courses included in the preliminary course will be:

Anatomy and Physiology.
Applied Chemistry.
Bacteriology.
Personal Hygiene.
Hospital Housekeeping.
Nutrition and Cookery.
Drugs and Solutions.
Elementary Nursing Principles and Methods.
Bandaging.
Historical, Ethical and Social Basis of Nursing.

The subjects following the preliminary course will include:

Materia Medica and Therapeutics.
Diet in Disease.
Massage.
Surgery.
Orthopedics.
Diseases of the Eye, Ear, Nose and Throat.
Operating Room Technic.
General Medicine.
Communicable Diseases.
Occupational, Venereal and Skin Diseases.
Nervous and Mental Diseases.
Diseases of Infants and Children.
Gynecology.
Obstetrics.

Public health nursing, social service and other subjects relating to the problems of the several fields of nursing and modern social conditions will be taken up in the third year.

VOLUNTEER MEDICAL SERVICE CORPS.

I. *What is to be gained by the establishment of this organization?*

a. To list and classify the availability of all physicians not in the military service of the fighting forces. In this way we hope to be prepared for any possible call on our medical resources in the future.

b. To furnish designating insignia for all members of the Corps that they may be spared unjust public criticism. Physicians who can serve in the Army, the Navy or Public Health Service but will not offer their services will not have the right to wear such insignia.

II. *Who are eligible?*

All doctors of medicine who would be accepted by the Reserve Corps of the several services were it not for physical disability, over-age (55), essential public need (boards of health and the medical care of isolated communities), essential institutional need (medical schools and hospitals), or dependents. Women physicians are eligible.

III. *How shall I apply for membership?*

By sending your application to the Central Governing Board, Council of National Defense, Washington, D. C. Application blanks may be obtained from this board or from your Executive Committee of the State Committee, Medical Section, Council of National Defense.

IV. *Who will determine my eligibility?*

State your qualifications on your application blank and submit three letters of recommendations. The application will be reviewed by the Central Governing Board and the Executive Committee. Final action will be taken by the Central Governing Board.

V. *How will a disability be determined?*

If you have been rejected for membership in the Reserve Corps on account of physical defect present your letter of rejection; otherwise apply for examination to a member of the Executive Committee or to any one he may designate.

VI. *What designation will be given me?*

The badge of the Volunteer Medical Service Corps which may be secured at a nominal price.

VII. *Does membership in the Corps carry with it rank and pay?*

The Corps itself gives no rank. Arrangements may be made between a member and the agency *requesting* ser-

vice. The question of compensation, whether with or without rank, must be determined at that time.

VIII. *When the services of a member are called for, is he to go where ordered whether in or out of this country?*

No member will be ordered to do any service. He may be *requested* to accept service commensurate with his qualifications and availability.

IX. *What service will probably be assigned to members?*

The future only can tell. However, General Blue of the Public Health Service has already requested the names of a number of men available for duty as sanitary officers. Names were sent him and definite arrangements were made between him and these members of the Corps. The organization will have information from the application blanks which will enable them to suggest substitutes for various places (hospitals, colleges, board of health, or isolated communities) needing physicians for the period of war.

X. *If later I find I may apply for and receive a commission, will I lose my membership in the Volunteer Medical Service Corps?*

Automatically by notifying the Central Governing Board that you have accepted a commission and are then in the Medical Reserve Corps.

XI. *Who is essential or indispensable in college, hospital, board of health, or isolated communities?*

Only he who occupies a position essential to the needs of a community and his place cannot be filled by a physician who is eligible for military service.

XII. *Is the physician of selective service age, who has been exempted because of dependents, eligible?*

No, unless his dependents are of such number that he cannot keep them on an officer's pay with commutation for quarters. Some men have claimed exemption entirely ignoring the fact that they are eligible for commissions with officer's pay.

XIII. *How can it be determined that a man's dependents are of such character that he cannot keep them on an officer's pay?*

This is a most delicate situation and must be decided with discretion and judgment by those charged with such affairs by the board. Precise data must be furnished by the applicant.

WAR NOTES

Dr. C. A. Cooper, of Milwaukee, has notified his parents of his arrival over seas.

Dr. H. M. Ripley of Kenosha, now in the service at Camp Greenleaf, Georgia, writes that enlisted men and officers would not know what to do without the Y. M. C. A. or Red Cross.

Dr. C. H. Nims of Oshkosh has entered the service at Camp Beauregard, Alexander, La. He was home on a few days' leave of absence.

Monroe county has seventeen physicians, and fifty per cent of the members have entered the service. The Baraboo Daily News calls attention to the fact that but one physician in that county has heard the call.

Dr. G. R. Reay, of La Crosse, who was ordered to Houston, May 10, after having received his training at Ft. Riley, has been sent to Camp Doniphan, Okla.

Dr. J. W. Lockhart, of Oshkosh, has entered the service.

The week of July 22 has been selected for the drive to complete the $1,000,000 endowment fund now being raised for Marquette university school of medicine.

The Carnegie Foundation, which so generously gave one-third of the $1,000,000 fund upon condition that the remainder be raised by July 1, has kindly extended the time, at the request of the trustees, until Oct. 1.

Preparations are now being made for a thorough canvass of the state, and the enthusiasm of the managers, which will be communicated to the workers in the field, gives promise that the amount will be quickly raised and that Milwaukee will become a great medical center with consequent benefit to the city, the state and the nation.

The campaign committee has selected the following executive committee, which will have charge of the drive:

Dr. H. V. Ogden, Judge A. C. Backus, Dr. Horace M. Brown, Dr. Hoyt E. Dearholt, Walter Kasten, Nat Stone, E. R. Wagner, Theodore Trecker and John M. Callahan.

The members of the campaign committee are: Louis Allis, Mrs. Louis Auer, Judge A. C. Backus, Dr. Horace M. Brown, John H. Callahan, Dr. Hoyt E. Dearholt, B. V. Dela Hunt, Mrs. Otto Falk, Mrs. James Hugh Hackett, Dr. Louis F. Jermain, Judge John G. Karel, Walter Kasten, John C. Kleczka, Mrs. John W. Mariner, Miss Elizabeth G. Marshall, Henry L. Nunn, Dr. H. V. Ogden, Dr. A. J. Patek, Judge M. S. Sheridan, Postmaster Frank B. Schutz, Nat Stone, Mrs. Henry Sullivan, Theodore Trecker, Mrs. Frank L. Vance, A. T. Van Scoy, Fred Vogel, Jr., E. R. Wagner, Dr. W. C. F. Witte.

A step long hoped for by medical men in the army and the United States as well was taken when it was announced that leading American surgeons doing volunteer work with American expeditionary forces have been given higher rank. This has long been advocated by the American Medical Association, on the ground that surgeons and physicians who are really doing big work should not be too far outranked by other army men.

The announcement promotes Dr. J. M. T. Findley, chief consultant of the medical service of the American expeditionary forces, and Dr. William S. Trayer, also chief consultant, from major to colonel.

It also promotes from major to lieutenant colonel the following: Thomas R. Roggs, James T. Case, George W. Crile, Harvey Cushing, Joel W. Golthwait, James F.

McKernon, Charles H. Peek, Thomas A. Salmon, Hugh H. Young, N. Allison and E. L. Keyes.

COMMISSIONS AWARDED.

The following have obtained commissions as officers in the M. R. C.:

W. T. Fletcher, Salem.
A. J. Joel, Auburndale.
G. E. Thompson, Kenosha.
R. B. Bach, Milwaukee.
F. E. Andrews, Kenosha.
T. W. Ashley, Kenosha.
H. A. Robinson, Kenosha.
E. A. Lamphan, Rib Lake.
J. A. Kiethley, Palmyra.
A. C. Jerend, Camden.
J. M. Baasen, Mt. Calvary.
H. C. Maurer, Beloit.
M. A. Nuzum, Janesville.
S. D. Cronk, Galesville.
F. W. Brockway, Oshkosh.
E. P. Allen, Waukesha.
W. F. Grotjan, Milwaukee.
E. J. Kraus, Milwaukee.
K. W. Smith, Madison.
A. S. White, Rice Lake.
C. K. Oliver, Boyceville.
E. J. Phelps, Elderon.
T. G. Parker, Rome.
L. W. Thrope, Milwaukee.
J. C. Cutler, Wauwatosa.
L. F. Rushaupt, Milwaukee.
V. F. Marshall, Appleton.
H. J. Gramling, Milwaukee.
T. H. Burback, Milwaukee.
G. F. Kenney, Milwaukee.
J. Littenberger, Milwaukee.
J. C. Zuercher, La Crosse.
W. B. Campbell, Menomonee Falls.
H. M. Kay, Madison.
F. D. Jackey, Thorpe.
Jens Anderson, Racine.
J. P. Dean, Madison.
C. U. Senn, Ripon.

ORDERED INTO SERVICE.

Dr. T. F. Shinnick, Beloit, to Rockefeller Institute, for a course of training.

Dr. C. S. Parker, Clinton, to Portland, Ore.

Dr. S. E. Gavin, Fond du Lac, to Camp Colt, Gettysburg, Pa.

Dr. T. J. Howard, 184 15th Street, has received orders from the adjutant general's office in Washington to report at once at Presbyterian Hospital, Chicago, for six weeks' special training before going on duty at the base hospital, Camp Grant.

Dr. L. J. Looze, Brodhead, to Rochester, Minn., for training at the Mayo Institute.

Dr. J. Sutherland, Brodhead, to Camp Dix, N. J.

Dr. G. M. Senn, Chippewa Falls, to Camp Gordon.

Dr. A. J. Pullen, North Fond du Lac, to Camp Cody.

Dr. C. W. Steffessen, Alderly, to Ft. Oglethorpe.

Dr. L. A. Hoffmann, Campbellsport, to Ft. Oglethorpe.

RECENT ORDERS ISSUED TO WISCONSIN PHYSICIANS IN SERVICE.

To Camp Lee, Petersburg, Va., for duty, from Army Medical School, Lieut Ira R. Sisk, Madison.

To Fort Oglethorpe, for instruction, from Camp Pike, Lieut. William W. Gillespie, Milwaukee.

To Hoboken, N. J., for duty, from Fort Oglethorpe, Capt. Frank E. Darling, Milwaukee.

To Camp Meade, Annapolis Junction, Md., for duty, Lieut. Arthur Charbonneau, Green Bay.

To Camp Pike, Little Rock, Ark., as a member of a board examining the command for tuberculosis, from Fort Riley, Capt. Henry C. Caldwell, St. Croix Falls. For duty, Lieut. Joseph P. Schlaikowski, Milwaukee.

To Chicago, Ill., Northwestern University School of Medicine, for instruction, Capt. Ernest L. Bolton, Chilton. Presbyterian Hospital, for instruction, and on completion to Camp Bowie, Fort Worth, Texas, base hospital, Lieut. Herbert F. Wolters, Milwaukee. On completion to Camp Grant, Rockford, Ill., base hospital, Lieut. Timothy J. Howard, Milwaukee. On completion to his proper station, from Camp Dodge, Capt. Paul J. Lewis, Bloomington.

To Hoboken, N. J., for duty, from Camp Mills, Major E. J. Barrett, Sheboygan; from Camp Custer, Capt. Albert A. Maurer, La Crosse; from Fort Oglethorpe, Capt. Frank E. Darling, Milwaukee.

To Lonoke, Ark., Signal Corps Aviation School, for duty, from Houston, Capt. Patrick R. Minahan, Fond du Lac.

To Otisville, N. Y., for duty, from New Haven, Capt. Michael R. Wilkinson, Oconomowoc.

The following order has been revoked: To Camp Kelly, San Antonio, Texas, for duty, from Camp MacArthur, Lieut. George W. Harrison, Ashland.

To Camp Colt, Gettysburg, Pa., for duty, Capt. Stephen E. Gavin, Fond du Lac.

To Camp Grant, Rockford, Ill., base hospital, from Fort Riley, Capt. Albert A. Axley, Butternut.

To Portland, Ore., Yeon Building, for duty, Capt. Albert A. Parker, Clinton; Lieuts. John C. Scott, Marinette; Worthington L. Rautz, Rosholt.

To Camp Devens, Ayer, Mass., as assistant to the camp surgeon, from Hoboken, Major E. J. Barrett, Sheboygan.

To Camp Grant, Rockford, Ill., base hospital, Lieut. Timothy J. Howard, Milwaukee.

To Portland, Ore., Yeon Building, for duty, from Arcadia, Lieut. Charles F. Rehling, Fremont.

To report to the Commanding General, Philippine Department, for duty, from Camp Custer, Lieut. Martin DuFrenne, Middleton.

To Washington, D. C., for duty, and on completion to his proper station, from Cape May, Capt. J. Gurney Taylor, Milwaukee.

To Camp Custer, Battle Creek, Mich., with the board examining the command for cardiovascular diseases, from Cape May, Capt. J. Gurney Taylor, Milwaukee.

To Camp Devens, Ayer, Mass., for duty, from Fort Oglethorpe, Lieut. Cornelius N. Stuesser, Oconomowoc.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Lieuts. William F. Baker, Birnamwood; Adolph L. Kyllo, Grantsburg.

To Fort H. G. Wright, L. I., N. Y., for duty, from Fort Oglethorpe, Lieut. Frank A. Boeckman, Greenwood.

To Fort McPherson, Ga., for duty, from Lakewood, Capt. Oscar C. Willhite, Lake Geneva.

Honorably discharged on account of physical disability existing prior to entrance into the service, Lieut. Neal S. Simons, Taylor.

BOOK REVIEWS

Surgical Clinics of Chicago. April, 1918, Volume 2, No. 2. (W. B. Saunders Company.) The April number, of this bi-monthly, contains a remarkable variety of cases including such unusual subjects as "Case of Rat-bite fever," by Brennemann; "The Extragenital Chancre as a Complication in Minor Surgery," by Mitchell; and "Pathologic Lesions Among Extinct Animals: A Study of the Evidences of Disease Millions of Years Ago," by Moodie.

Halstead and Dick present a most interesting case showing the necessity of a thorough and complete examination in each and every case, and the occasional insufficiency of only *one*, even if correct, diagnosis. "A Case of Syringomyelia with Arthropathy," in which the patient, ten weeks following an injury, presented himself complaining of swelling in elbow, with loss of strength of forearm and hand. X-ray revealed fracture of bones in elbow with exudate about joint and changes similar to myositis ossificans, a Charcot joint. But because of lack of proportion between the pathology and the symptomology, further study revealed Syringomyelia, which is succinctly discussed.

A short but instructive contribution by Watkins concerns, "The Technic and Diagnostic Importance of Palpation of Kidneys." What might be called one of the commonplaces of surgical diagnosis, but well worth study by all who presume to do abdominal operations.

Ochsner discusses the timely subject of Cholecystostomy vs. Cholecystectomy in which cholecystectomy as a routine procedure in the absence of definite organic obstruction of the duct, is condemned. He emphasizes a most important law in surgery, that is, "Never to remove anything unnecessarily," and states that the removal of a gall bladder is not always harmless. The gall bladder is sutured to the peritoneum and transversalis fascia, and tube drainage is replaced by gauze package.

Oliver shows the relationship of pathology and therapy in two similar, yet different, bone cases: one a spindle cell sarcoma of tibia requiring amputation. The other a giant cell sarcoma of the ulna in which the tumor was resected and an autogenous transplant inserted in its place.

F. G. C.

Medical War Manual No. 4. Authorized by the Secretary of War and Under the Supervision of the Surgeon-General and the Council of National Defense.

Infant Feeding. By Clifford G. Grulee, A. M., M. D., Assistant Professor of Pediatrics at Rush Medical College (in affiliation with the University of Chicago); Attending Pediatrician to Presbyterian Hospital, and to the Home for Destitute Crippled Children, Chicago. Illustrated. Third Edition, thoroughly revised. W. B. Saunders Co., Philadelphia and London, 1917.

The publication of a third edition of Dr. Grulee's work on Infant Feeding has enabled the author to incorporate in it the advances which have been recorded during the past three years without materially increasing the size of the volume.

The reviewer takes a great deal of pleasure in commending this volume for he considers it one of the best books in the English language on the subject. The author has a broad grasp of his subject, his ideas have been tested in the crucible of clinical experience, he writes clearly and in an interesting manner, and the book is well arranged and illustrated. The division of the book into four main parts, Fundamental Principles of Infants' Nutrition, Nourishment of the Infant on the Breast, Artificial Feeding, Nutrition in other Conditions, will indicate the scope of the work.

It is a well-balanced presentation of our present day knowledge of an important subject.

A. W. M.

The Medical Clinics of North America. Volume 1, Number 5 (The Chicago Number). Octavo of 241 pages, 35 illustrations. W. B. Saunders Company, Philadelphia and London, 1918. Published Bi-monthly. Price per year: Paper $10.00; Cloth $14.00.

This number holds to the standards established in the four previous issues. Doctors Mix, Strouse, Elliott, Tice, Williamson, Portis, Friedman, Hess, Wright, Byfield, Hamill, Abt, Hubeny and Helmholz have contributed clinical work which is faithfully recorded. Hamill's clinic on Insomnia and Hysteria, Friedman's on Reflex Gastric Disturbances and Epigastric Pain, and Mix's on Cardiac Conditions are alone worth many times the cost of the series. The Medical Clinics of America fill a long felt need for clinical reading by those away from teaching centers.

Clinical Lectures on Infant Feeding. Boston Methods, by Lewis Webb Hill, M. D., Junior Assistant Visiting Physician, Children's Hospital, Boston; Alumni Assistant in Pediatrics, Harvard Medical School. Chicago Methods, by Jesse Robert Gertstley, M. D., Instructor in Pediatrics, Northwestern University Medical School; Associate Attending Pediatrician, Michael Reese Hospital, Chicago. W. B. Saunders Co., Philadelphia and London. 1917.

This interesting volume represents a new method of post-graduate medical education and contains two sets of lectures delivered under the joint auspices of the University of North Carolina and the State Board of Health before two different groups of classes, one in the eastern and one in the western part of North Carolina.

One series of lectures presents the views on Infant Feeding which prevail in Boston at the present time, the other sets forth the ideas held by most of the teachers in Chicago, or in other words a modified continental European point of view.

Both sets of lectures are worthy of careful reading and the idea of combining them in a single volume is a very good one as it gives the medical man an excellent opportunity to weigh the merits of the teachings of the different schools of thought on this vital subject.

A. W. M.

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ORGANIZED 1841

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The Wisconsin Medical Journal, Official Publication

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Douglas	R. C. Smith, Superior	John Baird, Superior.
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Fond du Lac	G. B. McKnight, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
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Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
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Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
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Wood	Ed. Hougen, Grand Rapids	W. M. Ruckle, Grand Rapids.

ASSOCIATION NEWS

THE A. M. A. MEETING.

The annual meeting of the American Medical Association, held in Chicago the second week of June, will be long remembered by all in attendance. It was distinctly a military and patriotic meeting. The registration totaled 5,464 Thursday evening and doubtless reached the 6,000 mark before the end of the session. When it is considered that nearly one-fifth of the profession is in the Service and that this number breaks all records for attendance, the increased interest in medical affairs due to war conditions, is easily understood.

Three large patriotic meetings were held at the Auditorium and Medinah Temple. Governor Louden of Illinois gave a patriotic address on Tuesday evening. Many distinguished guests from this country and abroad took part in the military meeting Wednesday and addresses were made by Surgeon General Gorgas, Admiral Braisted, Sir James MacKinzie, Sir Arbuthnot Lane, Colonel Herbert Bruce of Canada, M. Justin Godart of France, Major Edourd Rist of France, Doctor Rene Sand of Belgium, Ray Lyman Wilbur and Major Alexander Lambert.

The next annual session will be held in Atlantic City in June, 1919.

Following is the result of the election of officers for the American Medical Association for the year 1918-1919:

President—Arthur Dean Bevan, Chicago.

President-Elect—Alexander Lambert, New York City.

First Vice-President—William M. Wishard, Indianapolis, Ind.

Second Vice-President—E. Starr Judd, Rochester, Minn.

Third Vice-President—C. W. Richardson, Washington, D. C.

Fourth Vice-President—John M. Baldy, Philadelphia, Pa.

Secretary—Alexander R. Craig, Chicago.

Treasurer—William Allen Pusey, Chicago.

Speaker of the House of Delegates—Hubert Work, Pueblo, Colo.

Vice Speaker of the House of Delegates—Dwight H. Murray, Syracuse, N. Y.

Board of Trustees—Frank Billings, Chicago; Wendell C. Phillips, New York City; Thomas McDavitt, St. Paul, Minn.; and to fill the vacancy occasioned by the death of E. J. McKnight, New Haven, Conn., for the term expiring 1919, D. Chester Brown, Danbury, Conn.

Member of the Judicial Council for a term of five years, W. S. Thayer, Baltimore, Md.; and to fill the vacancy occasioned by the election of Alexander Lambert, New York, as President-Elect of the Association, whose term would have expired in 1919, M. L. Harris, Chicago.

Member of the Council on Health and Public Instruction for a term of five years, to succeed himself, W. S. Rankin, Raleigh, N. C.; and to fill the vacancy occasioned by the election of Frank Billings, Chicago, as a member of the Board of Trustees, whose term would have expired in 1921, Ludvig Hektoen, Chicago.

Member of the Council on Medical Education, for a term of five years to succeed himself, Horace D. Arnold, Boston.

Member of the Council of Scientific Assembly, for a term of five years, to succeed himself, Roger S. Morris, Cincinnati.

NEWS ITEMS AND PERSONALS.

Dr. G. C. Ruhland, Commissioner of Health, Milwaukee, lectured July 26 before the war commission in health services, which is being given with the extension division in co-operation with the institutional division of the Red Cross. On the following day Miss Elizabeth Woods of the Chicago School lectured and W. S. Renolds of the United Charities also lectured.

Dr. M. J. Roudermund of Milwaukee, who has been in the limelight at various times, was recently convicted of performing a criminal operation and was fined five hundred dollars and his license revoked.

Through a special ruling of the State Board of Control, negroes will be admitted to the tuberculosis sanatorium at Statesan on the same basis as whites.

Dr. G. Windesheim, President of the State Medical Society of Wisconsin, is recovering from injuries which he received July 1st in an automobile accident. The doctor, in an attempt to prevent a collision with another car, turned his car on a slippery street and it turned over. He has the sympathy of the entire profession in the state.

A picnic lunch was given Wednesday afternoon at the Bay View Sanatorium by the nurses for their superintendent, Miss Stevenson, who has left her position here to be married.

Early in May the first institution was opened in the Milwaukee Children's Hospital in the "Saving Babies" drive. At that time those interested in Red Cross work and women's organizations had been taking instructions on weighing and measuring. The work at the hospital is in charge of Miss Gertrude McKee.

A petition was taken out on May 8th for a forty thousand dollar addition to the South View Hospital, Milwaukee.

Dr. G. H. Ripley of Kenosha was elected President of the Wisconsin State Board of Examiners at its meeting in Milwaukee July 26th. Dr. J. M. Dodd was re-elected secretary.

Dr. F. A. Southwick of Stevens Point has announced his candidacy for Congressman on the Republican ticket for the 8th congressional district.

Dr. John Barnesdaye who was indicted in Superior will be tried in the Federal court in Eau Claire next month. It is charged that the doctor purchased and disposed of large quantities of morphine, cocaine, heroin and opium. The counts charge the doctor with being a "dealer in narcotics" and that he obtained "dope" by use of so-called "order forms" issued by the commissioner of internal revenue and obtained from various firms in substantial amounts.

To aid in the campaign for nurses for the army and navy, training schools in the state will give credit for nine months' work to women who are college graduates and who have completed courses in physics, chemistry and biology.

This action is in accordance with a bill passed by the legislature.

The accredited schools for nursing in Wisconsin are:

Beloit Hospital, Beloit; Columbia Hospital, Milwaukee; Kenosha Hospital, Kenosha; La Crosse Hospital, La Crosse. Lakeside Hospital, Oshkosh; Luther Hospital, La Crosse; Madison General Hospital, Madison; Madison Sanitarium, Madison; Milwaukee Maternity Hospital, Milwaukee; Mercy Hospital, Janesville; Milwaukee Hospital, Milwaukee; Milwaukee County Hospital, Wauwatosa; Mount Sinai Hospital, Milwaukee; Hanover Hospital, Milwaukee; St. Agnes Hospital, Fond du Lac; St. Francis Hospital, La Crosse; St. Joseph's Hospital, Ashland; St. Luke's Hospital, Racine; St. Mary's Hospital, Green Bay; St. Mary's Hospital, Milwaukee; St. Mary's Hospital, Racine; St. Joseph's Hospital, Marshfield; Theda Clark Hospital, Neenah; Trinity Hospital, Milwaukee; Wisconsin State Hospital, Mendota; Riverside Hospital, Grand Rapids.

Polish men from Milwaukee, fighting in France, may be nursed by their Milwaukee sisters, for about 100 young Polish women signified their intention of taking the intensive course in nursing and war work which the Polish Relief Society in conjunction with the Y. W. C. A. started at the association building.

The graduation exercises of the Sinai Hospital School were held July 23. Thirteen were graduated. Drs. A. J. Patek and G. C. Ruhland gave the addresses.

The Plankinton property on Grand Avenue has been sold to the Marquette University. The property extends from Grand Avenue to Clybourn Street, 847 feet and from 15th to 16th Streets, 313 feet, and will enable Marquette to extend indefinitely.

Drs. H. E. Dearholt, J. W. Coon, G. Windesheim and H. Cohan attended the annual meeting of the National Tuberculosis Society at Boston in May.

Three hundred people attended the opening of the new Ladysmith Hospital May 30th.

Dr. John R. Whiffen of Janesville has been seriously ill.

The Fond du Lac dental surgeons have agreed to give their services free for a period of two years; eighteen members having pledged to give their support for one-half a day each month for two years.

Miss Gertrude Olmsted is the first Wisconsin nurse to return from the Balkan District. Miss Olmsted was formerly with the Wisconsin Anti-Tuberculosis Association, and was sent with the special commission to the Roumania District on June 7, 1917.

CORRESPONDENCE

THE DOCTOR AND THE INSURANCE COMPANIES.

I am somewhat astonished to find how widespread has been the effect of the short articles under the above heading, appearing in this Journal since the appearance of the February number. From every quarter of the State, and from other states, I am receiving letters from physicians endorsing and promising co-operation in the effort that is being made to improve our relations with the insurance companies as far as payment is concerned for making out casualty claims. Also, I have had several communications from agents and officers of insurance companies, in which they agree almost unanimously as to the justness of the claims of medical men for payment for this work. The following correspondence between Dr. Arthur Sullivan of Madison, and Mr. Geo. E. Tyrell, president of the Accident and Health Insurance Underwriters Association of Wisconsin, leads me to believe that if the medical men will bring this question fairly before the insurance companies, a way will be provided for a settlement of our quarrel with them, which shall be to our advantage. I would suggest that every member of the medical profession in this state who reads this article, write a letter to Mr. Tyrell urging upon him the importance of bringing this matter before his association for consideration and adjustment. As compared to the letter of Mr. Z. H. Austin of Minneapolis with its

insults and demands, Mr. Tyrell's letter proves that at least some of the insurance agents and officials are possessed of a sense of decency in their attitude toward the medical profession, and while we medical men should not cease to make every effort to secure our just rights, we should be ready to act in harmony with those men of the insurance companies who give evidence of a willingness to consider and respect our position in this matter.

H. M. Brown.

Madison, May 22nd, 1918.

The Wisconsin Accident & Health Ins. Co.,
Milwaukee, Wisconsin.

Gentlemen:

I have just filled in the final proof of accident for Mr. Joseph Klass, your claim number 17054.

There is a rapidly extending movement in this state, under the leadership of a prominent Milwaukee surgeon, to secure payment from the Insurance Companies for our labors in filling out such forms as I have just completed for you, without compensation. It has been almost universally the custom for physicians to devote the necessary time to filling in similar papers, and because of the poverty of most of the injured patients who carry policies similar to the one you issued to Mr. Klass, to waive the fee which was earned and should have been paid. The theory has been advanced that the patient pays you for his insurance and that you in turn should compensate the physician for the clerical work which is of advantage to neither the patient nor physician, but entirely to the insurance company, and which is consequently a necessary part of the conduct of your business. We are not bound by any moral or legal obligations to fill out these blanks. It is a time consuming, and frequently, because of the number of papers some of us are called upon to complete, a most annoying and non-productive feature of our daily routine. I am entirely in accord with the movement which emanates from Milwaukee and desire to notify you that I shall no longer complete your papers without being properly compensated by you. I should dislike to be put in the position of advising those patients who present final proofs from companies which do not pay the physician directly for his service, that they had best insure with a company which does. I am told that some of the companies are already making this provision and I am hopeful if you have not already adopted this plan that you will do so soon. I do the surgical work for a number of corporations, some of which employ several hundred men and the task imposed, possibly unintentionally by the insurance companies, has become a burden which I do not feel called upon to bear. I will no longer be the unpaid clerk for insurance companies.

I should appreciate hearing from you as to your attitude on the above matter. I am

Yours sincerely,

Arthur G. Sullivan, M. D.

Milwaukee, May 24, 1918.

Dr. Arthur G. Sullivan,
620 State Street,
Madison, Wisconsin.

Dear Sir:

Referring to your communication of the 22nd which has been referred to me, I desire to state

That heretofore it has always been the custom of both Casualty and Life Companies to require policy holders to make and file claim proofs at their own expense. The premium rates on Health and Accident Insurance were originally based upon this practice and they have never been changed.

While prices of every kind affecting both labor, material, professional as well, have soared, advancing during the last three years from 33⅓ to 75%, yet the prices of Accident and Health Insurance have remained the same.

The writer would gladly favor a change in the system if all, or nearly all, the Accident and Health Companies doing business in the State would consent to the change, but in order to do this it would probably necessitate a modification of premium rates somewhat owing to increased expense cost, war taxes, etc., which has made the margin very small in this line of insurance.

The writer being president of the Accident and Health Insurance Underwriters Association of Wisconsin will be very glad to bring the matter up before that organization at the next meeting, for their consideration.

Yours very truly,

Geo. E. Tyrell, *President.*

Dr. H. M. Brown,
79 Wisconsin St.,
Milwaukee, Wis.

Dear Dr. Brown:

Enclosed please find some correspondence which I trust you will return to me. I was quite surprised with Mr. Tyrell's concilliatory attitude, no doubt due to the news of your crusade having reached him.

At the last meeting of the Dane County Medical Society I read your letter which appeared in the last number of the Wisconsin Medical Journal and then urged them to co-operate with you in this fight. There was not much response, but I believe that as the days go by the force of your argument will strike home and the Insurance Companies will be receiving an increasing number of protests. I shall try to further the cause here and if anything unusual develops in the situation, would appreciate hearing from you.

With best wishes, I am

Yours sincerely,

Arthur G. Sullivan.

Dr. H. M. Brown,
79 Wisconsin St.,
Milwaukee, Wisconsin.

My Dear Dr. Brown:

Thank you for returning my correspondence with the Wisconsin Accident & Health Insurance Company. I have no objection to your including it in your article for the Wisconsin State Medical Journal. I am inclined to believe that Mr. G. E. Tyrell will try to secure the neces-

sary reform when the Accident & Health Insurance Underwriters Association of Wisconsin again meets, particularly if you Milwaukee men give him encouragement to take the initiative.

With best wishes, I am

Yours sincerely,

ARTHUR G. SULLIVAN.

COUNCIL OF NATIONAL DEFENSE.

WASHINGTON.

June 2, 1918.

From: Dr. Franklin Martin,
Member of Advisory Commission.

To: State Committees, Medical Section,
Council of National Defense.

Subject: Transmissible Diseases.

1. Transmissible diseases have been carried into many camps by drafted or enlisted men, and especially by men home on leave of absence. The Public Health Service, therefore, after conference with Army sanitary authorities, has drawn up a plan for the notification of camp medical officers. You can assist in seeing that the members of your community understand this plan, and facilitate it by exercising special care in reporting their cases of communicable diseases to the proper health authorities. The new plan of notification is as follows:

1. "The physician should make an immediate report to the local health authorities who should notify (by telephone or telegraph if necessary) the Senior Medical Officer of the camp or post to which the selected man or soldier may become a menace. A duplicate notification should be made by the local authorities to the State health authorities.

2. If there be no health authority having jurisdiction, the physician should notify (by telephone or telegraph if necessary) the State health officer who should notify (by telephone or telegraph if necessary) the Senior Medical Officer of the camp or post to which the selected man or soldier is about to go.

3. The notification should be explicit, giving name of selected man or soldier and other identification data together with his address and the nature of the disease.

4. The notification of the Senior Medical Officer of the camp or post by the local or State health authorities should be in addition to the present procedure in such case."

By direction of Dr. Franklin Martin,
JOHN D. MCLEAN, *Major, M. R. C.*,
Secretary, Committee on States Activities,
General Medical Board.

AMERICAN MEDICAL ASSOCIATION.

Chemical Laboratory.

535 North Dearborn St., Chicago, June 12, 1918.

Dr. Rock Sleyster, Editor,
Wisconsin Medical Journal,
Waupun, Wisconsin.

Dear Sir:

Professor Stieglitz, Chairman of the Subcommmittee on Synthetic Drugs of the National Research Council, has asked me to send you the enclosed letter for publication.

On behalf of the Committee, he also urges that you adopt the Federal Trade Commission's recommendation to use the official name of the licensed drugs in connection with all written articles and advertisements, and if the proprietary brand name is to be used, to place this side by side with the official name.

The official names so far adopted by the Federal Trade Commission are:

Arsphenamine for the drug marketed as: Salvarsan, Diarsenol and Arsenobenzol, etc.

Neoarspheuamine for the drug marketed as: Neosalvarsan, Neodiarsenol and Novarsenobenzol, etc.

Neodiarsenol and Novarsenobenzol, etc.

Barbital for the drug marketed as Veronal.

Barbital-Sodium for the drug marketed as Medinal and Veronal-Sodium.

Procaine for the drug marketed as Novocaine.

Procaine Nitrate for the drug marketed as Novocaine Nitrate.

Phenylcinchoninic Acid for the drug marketed as Atophan.

Yours truly,

W. A. PUCKNER.

PROCAINE AND NOVOCAINE IDENTICAL.

To the Editor:

It appears that in certain quarters the attitude is taken that the local anesthetic sold as Procaine is not identical with that marketed as Novocaine. The Subcommittee on Synthetic Drugs of the National Research Council believes it important that this misunderstanding should be corrected and hence offers the following explanation:

The monohydrochloride of para-amino-benzoyldiethylamino-ethanol, which was formerly made in Germany by the Farbwerke, vorm. Meister, Lucius and Bruening Hoechst A. M., and sold under the trademarked name Novocaine, is now manufactured in the United States. Under the provisions of the Trading with the Enemy Act, the Federal Trade Commission has taken over the patent that gave monoply for the manufacture and sale of the local anesthetic to the German corporation, and has issued licenses to American concerns for the manufacture of the product. This license makes it a condition that the product first introduced under the proprietary name "Novocaine" shall be called Procaine, and that it shall in every way be the same as the article formerly obtained from Germany. To insure this identity with the German Novocaine, the Federal Trade Commission has submitted the product of each firm licensed to the A. M. A. Chemical Laboratory to establish its chemical identity and purity, and to the Cornell pharmacologist, Dr. R. A. Hatcher, to determine that it was not unduly toxic.

So far, the following firms have been licensed to manufacture and sell Procaine:

The Abbott Laboratories, Ravenswood, Chicago.
Farbwerke-Hoechst Company, New York, N. Y.
Rector Chemical Co., Inc., New York, N. Y.
Calco Chemical Company, Bound Brook, N. J.

Of these, the first three firms are offering their products for sale at this time, and have secured their admission to New and Nonofficial Remedies as brands of Procaine which comply with the New and Nonofficial Remedies standards.

While all firms are required to sell their product under the official name "Procaine", the Farbwerke-Hoechst Company is permitted to use the trade designation "Novocaine" in addition, since it holds the right to this designation by virtue of trademark registration.

In conclusion: Procaine is identical with the substance first introduced as Novocaine. In the interest of rational nomenclature, the first term should be used in prescriptions and scientific contributions. If it is deemed necessary to designate the product of a particular firm, this may be done by writing Procaine-Abbott, Procaine-Rector, or Procaine-Farbwerks (or Procaine (Novocaine brand)).

Yours truly,

JULIUS STIEGLITZ,
Chairman Subcommittee on Synthetic Drugs,
National Research Council.

BOOK REVIEWS

Military Orthopaedic Surgery. Prepared by the Orthopaedic Council. Illustrated. Lea & Febiger, Philadelphia and New York, 1918. This admirable manual, while designed especially for the guidance of the Medical Officers in Orthopaedic work, will be found of great help as well to the general surgeon, both in military and civil practice.

The first four chapters are devoted to the human foot, its physiology, abnormalities and disabilities, especially as related to the soldier. Other chapters are devoted to,

Injuries to Joints and Their Treatment.

The Disabilities of the Knee-Joint.

Positions of Election for Ankylosis following Gunshot Injuries of Joints.

The Spine—Its Physiology, Examination and the Significance of its Abnormalities.

Methods of Treatment for Disabilities following nerve injuries.

Ununited and Malunited Fractures.

Bone Grafting.

Methods of Fixation. Plaster-of-Paris Dressings, Splints and Other Apparatus.

While very much condensed, sufficient space is devoted to underlying principles to give the reader a clear idea of the reason for the various modes of treatment outlined. In the preface the authors state that they deemed it wise to profit by the experience of our Allies. Accordingly several chapters are taken from the writings of Col. Sir Robt. Jones. The chapter on the prophylaxis of the foot is taken largely from the work of Colonel Munson, U. S. A. A supplement on the method of fixation published by the Board of Medical Officers in France, A. E. F., should prove of great value in the use of various standard splints and apparatus.

The authors are to be congratulated on having produced this excellent manual in a very short space of time. It is to be hoped that many not now in the service will become acquainted with this manual in view of the fact that many more medical officers will be needed in the service, some of whom will undoubtedly be called upon to do work in this line. F. J. G.

Interpretation of Dental and Maxillary Roentgenograms. By Robert H. Ivy, Major, M. R. C. 146 pages, 259 illustrations. C. V. Mosby Company, St. Louis, 1918. Price $2.50.

This work will appeal to us as it is by one of our own Wisconsin physicians now in service assigned as chief of his division in the Surgeon General's office. Our personal knowledge and the Governmental recognition given the Author is sufficient guarantee in this state. The purpose of the volume is to present the data necessary for making an intelligent diagnosis of pathologic conditions about the teeth and jawbones in which roentgen examination plays a part. In this work it is to the interpretation rather than to the technic that the writer has endeavored to call attention. A departure from the usual method of presentation lies in the fact that in this work the roentgenograms are negative reproductions, bone and hard tissue being light and soft tissues and spaces dark. After a chapter given to general considerations, the anatomy of the teeth and jaws with special refernce to Roentgenograms interpretation is taken up. Then pathology, correlation of clinical findings with roentgenographic examinations, findings in their relation to prognosis and treatment, steroscopic and other methods of localization, and finally interpretation given in detail.

The work is beautifully printed and illustrated on an art paper needed for such illustrations. This is authority on the subject and all progressive physicians should become familiar with the newer work along this line and be able to interpret this work so necessary now.

A Treatise on Clinical Medicine. By William Hanna Thomson, M. D., LL. D., Second Edition, Revised. Octavo volume of 678 pages. Philadelphia and London. W. B. Saunders Company. Cloth, $5.50 net.

Dr. Thomson, in his second edition, has recapitulated the subjects treated in the former edition of this excellent work, such as "Catching Cold", and the classification of diseases according to their exciting causes. Particular attention is given in the new edition to newer subjects such as the applications of different rays of light in both the diagnosis and treatment of malignant disease. A chapter on the significance of such common but important symptoms as emaciation, cough, dyspnoea, edema and vomiting will be of special interest to the general practitioner. The infections are admirably covered in five chapters and then the diseases of special tissues or organs are taken up in regular order. The book is well printed on an excellent grade of paper and is most readable. The book will be of real service to any physician actively engaged in the practice of general medicine.

Military Surgery. By Dunlap Pearce Penhallow, S. B., M. D. (Harv.), Major, M. R. C., U. S. Army, with an introduction by Sir Alfred Keough, K. C. B., Director General Army Medical Service. 555 pages. Illustrated. Published by Oxford University Press.

This book is well written and makes excellent reading. It carefully describes the different missiles used for destroying human life in time of war. It describes velocity and character of all missiles and the character of wounds produced by them. The Bacteriology of wounds is fully covered, as is the subject of immunity and serum treatment. Much space is given to the preparation of Dakin's solution and the methods of irrigating suppurating wounds. Amputations, fractures, head surgery, wounds of joints are fully described, also their functional results, and many new ideas are given in the treatment of fractures by new extension apparatus. Bone plating is given wholesome consideration and the author claims under many conditions it is justifiable. The importance of careful treatment of scalp wounds is emphasized and taken up at length. The book is divided into 14 chapters, is profusely illustrated and is a valuable contribution to military surgery.

Reclaiming the Maimed—A Handbook of Physical Therapy. 128 pages, illustrated. The MacMillan Company, New York, 1918. Price $2.00.

This little work is by Major R. Tait McKenzie, R. A. M. C., Professor of Physical Therapy, University of Pennsylvania. It is founded on an experience of over a year as Medical Officer in charge of the Command Depot at Heaton Park, Manchester, and as Inspector of similar institutions for the treatment of convalescents founded by the War Office throughout the British Isles. It covers the planning and equipment of institutions for this purpose, tells of the cases capable of improvement by physical means, covers the subjects of electricity, heat, light, hydrotherapy, massage, re-education, gymnastics, occupation and masking of facial deformities. It is wonderfully illustrated and will be of interest and help to all who are giving thought to the big problem of caring for our own injured and maimed.

Oral Sepsis in its Relationship to Systemic Disease. By William W. Duke, M. D., Ph. B. 124 pages, 170 illustrations. C. V. Mosby Company, 1918. Price $2.50.

This is a splendid companion book to that reviewed in this issue by Doctor Ivy. The book presents briefly and clearly the rather complex relationship which frequently exists between infections of the gum and alveolar process and certain systemic disorders. The work carefully covers pyorrhea alveolaris, alveolar abscesses, metastatic infection, nonrelated infection, toxic effect of oral sepsis and headache as related to oral sepsis. A final chapter of much value is given to summary and conclusions.

The work is beautifully printed on a rich art paper to correspond with the Ivy book and the illustrations are exceptional. The work is excellent from every standpoint.

Infection and Resistance. By Hans Zinsser, Professor of Bacteriology at Columbia University. 585 pages, illustrated. Second Edition. The MacMillan Company, New York, 1918. Price $4.25.

Since the publication of the first edition of this book four years ago it has been accepted as the standard work on the subject. It has been re-written and brought up to date in every respect. The chapters on Anaphylaxis have been completely re-written. The Aberhalden reaction having been proved to be an interesting camouflage, the material in that section has been revised and the more recent work on Enzymes added. The development of conceptions of non-specific serum and cellular reactions has been discussed, while a section on Immunity in Syphilis has been added and the chapter dealing with specific therapy in various infections has been revised and expanded.

The problem of virulence, Bacterial Poisons, Immunity, Toxines and Antitoxines are first covered; then the Bactericidal Properties of Blood Serum, the Complement-Fixation Method, The Phenomenon of Agglutinatoin, then Precipitation, Phagocytosis, Anaphylaxis, and finally Therapeutic Immunization in Man, Enzymes and Colloids.

This work seems absolutely complete and is the last word on the subject.

Diabetic Manual. By Elliott P. Joslin, Assistant Professor of Medicine, Harvard Medical School. 187 pages, illustrated. Lea & Febiger, Philadelphia and New York. Price $1.75.

The Author has given in this work in concise schematic form the modern conception of diabetes and its treatment. It is elementary in the hope that a book of this nature, written in the light of recent discoveries in the laboratory and clinic will be helpful to the general practitioner and a text book to his patient, thereby securing his intelligent co-operation and raising the standard of diabetic treatment. The Author refers to his work as a "Diabetic Primer" and there can be no question that such a book fills a very necessary need. It will prove to the medical man a valuable aid, not only in reviewing quickly the new work done, but is so written that it can be placed in the hands of his patient with the assurance that it will be read and understood. It is arranged in four parts. First, it gives in simple language a rapid survey of the whole subject, then traces with more detail the general field and outlines treatment of the severer diabetic. Part three contains diet tables and recipes. Part four is given to the various tests. This is a work well worth while and many physicians will order a second copy.

Emergencies of a General Practice. By Nathan Clark Morse, A. B., M. D., F. A. C. S. 449 pages, 251 illustrations. C. V. Mosby Company, St. Louis, 1918. Price $4.50.

The scope of the book is expressed in the title. It deals with emergency work, work in which the physician is called on to think and act quickly. Reference is also made to such conditions as appendicitis, tubal rupture, acute pancreatitis etc., emergency cases though distinctly surgical. This work should prove of value to the general practitioner and prove of material value to all medical men subject to calls of an emergency nature. The treatment of wounds, the removal of foreign bodies, the treatment of such accidents as asphyxiation, drowning, smoke, gas and electrical shock is all covered in the first chapters. Then the various surgical and medical emergencies are carefully taken up. The paraffin method of treating burns is well dealt with. Chapters are devoted to fractures, dislocations, amputations, obstetrical emergencies and poisonings. The work is well printed on on excellent paper, bound in a handsome red cloth and beautifully illustrated.

It is said by Tabarienus, that if the tongue of an Hoopoe be suspended above one that is insensible, then shall he recover his memory, and other rationals.—*Alb. Magnus.*

The hoofs of a horse burned in a house drives out mice. The same if it be of the hoofs of a mule.—*Alb. Magnus.*

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ORIGINAL ARTICLES

EPIDEMIOLOGY OF ACUTE APPENDICITIS IN RELATION TO ACUTE NASAL AND TONSILLAR INFECTIONS.*

BY J. S. EVANS, M. D.,

MADISON.

The consideration given the clinical aspects of acute and chronic appendicitis in this symposium properly directs attention to a special side of the etiology of the disease which may have an important bearing upon its prevention.

That appendicitis is invariably an infectious process has been definitely established. Certain observers[1] have emphasized the etiologic relation of those organisms usually found in the intestinal tract while others[2] argue that the infection is hematogenous in origin and is never caused by primary invasion of bacteria from the lumen of the organ. Also the occurrence of appendicitis in epidemic form[3] and its relation to acute infections has received much attention since the recognition of the disease has become more general. On the other hand, the predisposing factors which produce that lessened resistance necessary to the localization of the infecting agents are open to discussion. It is the concensus of opinion, however, that anything which disturbs the circulation of this organ, undergoing as it does a progressive retrograde metamorphosis after childhood, acts as an important predisposing factor. We, therefore, must concede that there are definite processes involved in the etiology of this disease other than the primary entrance of an infecting agent into the human organism; such processes are yet to be definitely determined if prevention is to be reasonably successful. It is fitting, however, that we consider at this time any data, resulting either from laboratory investigation or from clinical observation, which may be of assistance in the solution of the problem as a whole.

The elective affinity of the streptococcus group for certain tissues and organs has been demonstrated by Rosenow[4] who was able to produce appendicitis in 68 per cent of animals inoculated with cultures of streptococci isolated from cases of appendicitis, while only 5 per cent of the animals were so infected by cultures of streptococci isolated from widely varying sources. Such convincing laboratory results should stimulate investigations to determine the *clinical* evidence of a definite relation between pyogenic infections, localized at or near the portal of entry, and the morbidity curve of acute appendicitis. If such evidence exists, we may properly conclude that acute appendicitis is an acute metastatic focal infection in such proportion of instances as may be supported by the findings in of considerable number of cases. It is the purpose of this paper, therefore, to present the result of our observations upon the relation between pyogenic infections of the upper respiratory tract, the most frequent portal of entry, and the morbidity curve of *acute* appendicitis during the fifty-nine months from February, 1910 to June, 1916, inclusive.

During this period there were 236 cases of acute appendicitis in over 16,000 students at the University of Wisconsin, an *average* of 4 cases per month. Because of the variations in the university population from year to year the expectant rate of this disease (based on the number of students consulting the University Clinic) should vary from about 1 case per month in 1910 with a gradual increase to 4 cases per month in 1916. In the same period the expectant rate of acute upper respiratory infection shows a similar type of gradual increase.

The analysis of the cases of appendicitis from the standpoint of the frequency of a primary focus of infection preceding the onset of the appendiceal symptoms resulted as follows: Of the 236 cases, 214 or 91 per cent, were primary attacks, while 22, or 9 per cent, were recurrent infections. Of the 214 cases we find that in 183, or 86 per cent, there

*Read at the Meeting of the State Medical Society, October 4, 1916.

were observed definite primary infections of the upper respiratory tract, while no such evidence was at hand in 31, or 14 per cent. The primary respiratory infection preceded the acute appendiceal attack on an average of 16 days, the minimum interval being 1 day, the maximum, 60 days. It was noted during the study of the individual cases that appendicitis most frequently followed the subsidence of the constitutional symptoms accompanying the acute nasal or throat infections. We concluded, therefore, that metastasis from such pyogenic foci takes place when the organisms have lost a certain degree of virulence due to the focalizing processes at the original point of entrance. This is a point emphasized both by Billings[6] and by Rosenow[4]. The average interval of 16 days bears out this clinical observation, since our records show that the average period of constitutional disturbance in the acute upper respiratory infections does not exceed 5½ days. The few cases in which the maximum interval was approached probably were cases of delayed metastasis, the result of a more chronic type of focalization at the portal of entry.

In studying the morbidity curve of appendicitis from month to month we find that at eight periods during the six years there were marked increases above the expectant rate. Since similar increases above the expectancy of acute upper respiratory infections attended these same periods, we consider the evidence of an etiologic relationship between the two diseases the more definite. In *January, 1911*, there occurred a rather widespread epidemic of acute upper respiratory infections due to a diplococcic form of microorganism. During this epidemic 8 cases of acute appendicitis occurred in 14 days. In *December, 1912*, an epidemic of tonsillitis was complicated with 6 cases of appendicitis in 13 days, the infecting agent being a short chain streptococcus. Again in *December, 1913* a similar epidemic occurred similarly associated with 6 cases of appendicitis in 14 days. In *January-February, 1914*, accompanying a severe epidemic of streptococcic naso-pharyngeal infection there were 13 cases of appendicitis in a period of 32 days. In *October-November, 1914*, a similar epidemic was encountered and again we found an increase in the incidence of acute appendicitis, 27 cases occurring in 52 days. In *January-February, 1915*, 21 cases of appendicitis occurred in 43 days, associated with an epidemic of streptococcic tonsillitis. In *October-November, 1915*, there were 14 cases in 24 days accompanying a similar epidemic. During *January-February, 1916*, a severe pneumococcic epidemic spread from coast to coast and produced at the university a marked increase above the expectant rate, both in acute nasal and tonsillar infections and in acute appendicitis; 18 cases of the latter occurring in 26 days. The total number of cases in these eight periods was 113 and the total number of days involved 226, or an average of one case of appendicitis every 2 days. This is in such sharp contrast to both the average monthly rate and to the expectant rate for each of the fifty-nine months that one is justified in considering each group of cases as a definite epidemic.

Last year Rosenow and Dunlap[5] investigated a similar epidemic at Culver Military Academy and found that both mumps and appendicitis followed an epidemic streptococcic infections caused by the dairy products of the school. In this series of cases the laboratory results proved a direct relationship between the dairy products, the mumps epidemic and the appendicitis epidemic.

In this group of 113 cases we were dealing with microorganisms of the streptococcus group possessing a definite tropism for the appendix. This is witnessed both by the increased incidence between appendicitis and the pyogenic infections and the decrease in the interval between the primary infection and the acute appendiceal symptoms. Of the total number of students having acute upper respiratory infections only 1.5 per cent developed acute appendicitis, while 3 to 3.5 per cent of the students having such infections during the epidemic periods developed an acute infection of the appendix. The interval between the primary respiratory and the metastatic appendiceal infection in this group was cut down from an average of 16 days to an average of 8 days during epidemic periods. In this group 106 cases, or 93 per cent, had a demonstrable primary upper respiratory infection as compared with only 10 per cent of the total enrollment in the university showing such an infection. Of the entire series of appendicitis cases only 86 per cent gave similar evidence of nose and throat infections, while 58 per cent of the total enrollment during the six years consulted the Clinic for such infections. This percentage of incidence brings both the entire group of appendicitis cases, but especially the group occurring in epidemic form, far above the expectant rate.

The existence of predisposing factors is also ob-

vious and demands no detailed discussion, since each epidemic followed the return of the students to the university from one of the recesses. During such holidays the exposure incident to railroad journey, the usual indiscretions in diet and the overactivity due to change of environment undoubtedly acted as predisposing factors, not only in producing appendicitis but also in increasing the general morbidity curve. This influence is best shown by comparing the situation encountered in December, 1912, and December, 1913, with the same months in succeeding years. The two epidemics followed the Thanksgiving recess. This vacation was abolished in 1914 since which time there has been no epidemic of these two diseases in December.

It must be borne in mind that these acute infections play an important role in the general mechanism of lowered resistance, as well as serving as a primary source of infection in appendicitis. While tropism of microorganisms of the streptococcus group for special tissues has been rather conclusively proven experimentally by Rosenow[4] it is probable that the localization in the appendix is not only due to the development of a selective strain of the microorganisms but that the primary infection is one of the important factors in the lowered resistance of the appendiceal region as an expression of general lowered resistance. Each phase of this mechanism presents a more or less distinct problem for experimental and clinical study. Physicians in general have at one time or other been impressed by the periodic incidence of appendicitis. From the statistical clinical evidence of our records, definite epidemic incidence of acute infectious appendicitis is indicated. Furthermore, such fluctuations above the expectant rate of acute appendicitis succeed after a definite interval of focalization similar waves of acute upper respiratory infection. The conclusion of a definite relationship between acute upper respiratory infections and acute infectious appendicitis seems warranted and should direct our definite efforts to the practical prevention and control of the former.

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VALUE OF THE COMPLEMENT FIXATION TEST IN THE DIAGNOSIS OF TUBERCULOSIS.*

BY J. J. SEELMAN, M. D.,

MILWAUKEE.

For many years laboratory workers have been endeavoring to perfect a test that would be really helpful in the early diagnosis of tuberculosis. Miller[1] gives a tabulated abstract of the work done prior to August, 1916. Up to that time the most encouraging results seem to have been obtained by Besredka, Craig, and Miller and Zinsser. Besredka's work, however, was not satisfactory because he frequently encountered what he considered cross-fixation with syphilitic sera. Craig apparently overcame this difficulty by modifying the Besredka antigen. He obtained with his modified antigen, 96.2 per cent positive findings in active, 66.1 per cent in inactive tuberculosis, and no fixation whatever in non-tuberculous and syphilitic sera. Miller and Zinsser worked with an antigen prepared by triturating living or dead tubercle bacilli with dry salt, subsequently adding distilled water up to isotonicity. Two hundred and twenty-nine of 232 cases of active tuberculosis gave positive reactions with this antigen; 83 of 90 inactive cases were negative. Only 2 of 45 positive Wassermann cases gave fixation; in one of these tuberculosis was subsequently proven. One hundred and three non-tuberculous cases were all negative.

*Read before the Milwaukee County Medical Society, Feb. 8, 1918.

Since Miller's summary a number of investigators have published further findings. Corper[2], working with an autolysate, obtained only 30 per cent fixation in both active and inactive cases, and 1 positive in 25 clinically non-tuberculous individuals. Miller[3], using his salt extraction bacillus, reports 275 positives in 284 active pulmonary cases: 103 negatives in 113 inactive cases; no fixation in syphilitics in whom tuberculosis could be excluded; no positives in 144 clinically non-tuberculous cases.

With his modified Besredka antigen Craig[4] reports 96.6 per cent fixation in 149 active cases, and 65 per cent fixation in 60 inactive cases; of 350 syphilitics 5.4 per cent gave positive tuberculosis fixation, but he believes these all cases of incipient tuberculosis; of 100 cases suffering with diseases diagnosed as being other than tuberculosis 4 per cent gave positive fixation, all having diseases of the respiratory tract and most probably, in the opinion of Craig, tuberculous; of 200 supposedly healthy men tested only one gave fixation and he developed definite symptoms of tuberculosis shortly after the test.

Burns et al[5], in a series of 125 cases of clinical tuberculosis obtained 75.2 per cent fixation in all stages. While they do not definitely classify their cases as active or inactive, a study of their tables shows that the former give stronger and more frequent fixation than the latter. Their work indicates that the test may aid in determining the value of therapeutic measures, particularly the effects of rest and exercise. They employed the Miller antigen.

Corper and Sweeney[6], using Corper's autolysate, obtained the following results: in 31 supposedly non-tuberculous cases 19.3 per cent positive; in 69 questionable cases 43.4 per cent positive; in 192 active cases 60.4 per cent positive; in 35 inactive cases 48.5 per cent positive. They ran their autolysate alongside the Miller antigen and found the former slightly more antigenic and less anticomplementary than the latter.

In 100 cases reported by Ives and Singer[7], tested with the Fleischer-Ives antigen[8], 55 of 59 or 93.2 per cent of clinical pulmonary tuberculosis, and 10 of 27 or 37 per cent of suspected pulmonary tuberculosis gave positive reactions. Of 14 cases diagnosed as being other than tuberculosis one gave a positive reaction. This was a case of pelvic cellulitis which, they say, may have been tuberculous.

From these figures one turns, with no inconsiderable degree of surprise, to the literature of this same period on the subject of the early diagnosis of tuberculosis. One finds Pottenger[9], as late as September, 1917, discussing the important advances in the diagnosis of tuberculosis without a single reference to the complement fixation test. Lyman, Morgan, Hawes[10], in papers on the diagnosis of tuberculosis read before the Section on Tuberculosis of the Massachusetts State Medical Society in June of 1917, do not once refer to the test. Ewart[11], in September, 1917, discusses with much earnestness the importance of recognizing the pre-pulmonary stage of tuberculosis. He agrees with Head[12] that certain obscure clinical phenomena of a given type are frequently due to concealed tuberculosis, and makes a plea for the proper diagnosis and classification of these cases. Not a word, however, about the complement fixation test. Halperin[13], Harris[14], Hatch[15], Strouse[16], all writing during the year just passed on the early diagnosis of tuberculosis, do not refer to the test.

One does not expect the clinician to accept without question the offerings of the laboratory, even when these are presented by men of such high standing and unquestioned ability as have put their stamp of approval on the complement fixation test for tuberculosis. One expects, however, that they would at least question and investigate. That this has not been done is surprising.

My own series comprises 364 tests made on that many cases. The technic employed in the beginning of the work was the classical Wassermann test, except that the native anti-sheep amboceptor content of each serum was ascertained and allowed for. The technic was later modified so that each serum was tested with increasing amounts of antigen. This is the technic advised and described by Ives[7], and gives excellent results. The antigen used was the Miller[17]. In the latter part of the work the Fleischer-Ives antigen, kindly furnished by Dr. Ives, was run with the Miller, and gave equally good results.

Group 1 contains the findings on 128 bloods obtained from the Muirdale Sanitarium for tuberculosis. The specimens examined were in each instance part of the blood taken routinely for Wassermann tests from inmates of or applicants for admission to this institution. This group I have divided into Incipient, Moderately Advanced, Far

Advanced and Non-tuberculous cases, according to the records furnished by the Sanitarium.

The incipient cases were 21 in all. Of these 16 or 76-1 per cent were positive and 5 negative. Seventeen were considered active at the time the tests were made, and of these 15 or 88.2 per cent gave positive reactions, while 4 which were considered as probably inactive gave fixation in 1 and no fixation in 3 cases.

Of the 50 moderately advanced cases 34 or 68 per cent gave positive reactions while 16 were negative. Of 37 of these cases considered as being active 33 or 89.1 per cent were positive and 4 negative. Thirteen cases considered as being probably inactive at the time the tests were made gave one positive and 12 negatives.

There were 42 far advanced cases, of which 27 or 64.2 per cent were positive and 15 negative. Thirty-seven were active cases of which 25 or 67.5 per cent were positive. Five were inactive cases of which 2 were positive.

I have a series of 15 cases in which the clinical diagnosis was doubtful at the time the tests were made. This series was originally larger, but those cases which later developed clinical signs of tuberculosis have been classified with the definitely tuberculous cases, as that is where they rightfully belong. This is, then, in effect a group of persons who presented symptoms sufficiently suggesting tuberculosis to warrant examinations at the sanitarium, but in whom no definite signs of the disease were found and in whom no definite symptoms of the disease subsequently developed. Of these 13 were negative and 2 positive.

Group 2 contains the findings on the bloods of 236 supposedly non-tuberculous individuals. These were selected from cases that presented themselves at the laboratory for Wassermann tests. The cases selected were well nourished individuals, with good family history, and whose symptomatology in no way suggested tuberculosis. No physical examinations were made. Though this would, of course, have been desirable, it was impracticable because, as already mentioned, the cases were all individuals referred for Wassermann tests, and such examinations would have been considered uncalled for meddling. The results are interesting, however, in that they give the findings on a selected group of what may be called non-symptomatic individuals.

Of the 236 bloods 24 or a trifle over 10 per cent were positive. Positive Wassermann reactions were also obtained on 16 of these 24. There is still some diversity of opinion as to the interpretation to be placed on findings obtained with the Miller antigen on Wassermann positive bloods. Because the Wassermann reaction is not a specific reaction, it was thought that lipotropic substances in syphilitic bloods may combine with the lipoids of tuberculous antigens and bring about complement fixation. Bronfenbrenner[18], however, claims that the fixing bodies in these cases show an index which differs from the lipotropic index of the blood, and furthermore that in serums which fix with both the tuberculous and syphilitic antigens it is possible to exhaust one fixing substance without affecting the other. He also says that these cases lose their fixing power for syphilitic antigens under salvarsan treatment.

The number of positive reactions obtained on supposedly non-tuberculous individuals will depend to a large extent on the hygienic status of the group under observation. Thus Craig[4] among healthy young soldiers found the test 99.5 per cent negative. Most workers have found a certain per cent of positive reactions among the supposedly negative group. In groups selected by physical examination the proportion of such positives will depend to some extent on the diagnostic keenness of the examiner who marks the cases non-tuberculous. When we remember that we are always exposed to infection by the tubercle bacillus, and that many of us not infrequently become inoculated and fight and overcome the invader without developing any symptoms or signs of the disease, during which struggle antibodies are formed, we can easily explain the occurrence of positive fixation tests even in a carefully selected supposedly negative group.

The rather high percentage in my own series can be explained by the fact that this non-examined group consisted entirely of individuals who for some reason or other had sought medical advice, and were under the suspicion of harboring syphilis. If the incidence of tuberculosis among syphilitics is really as high as is indicated by some of the more recent work, one would easily expect to find 10 per cent of active cases of tuberculosis in such a group as I have presented.

The work done on complement fixation in tuberculosis in the past two years is more uniform and far more encouraging than that done previous to this time. There are still some variations in per-

centage findings, but these can be explained in part by the employment of different antigens and different technic by different workers, and in part by differences in the classification of cases. It is to be regretted that workers do not indicate more definitely the technic employed in obtaining the findings reported. When dealing with bacillary antigens such as the Miller, where the range between the anti-complementary and the antigenic dose is rather narrow, the results improve as the delicacy of the test is increased. An exceptionally careful adjustment of the ingredients of the hemolytic system and of the antigen and serum dose is imperative. It should also be remembered that different guinea pig serums, even if of the same complement strength, vary in fixing qualities for tuberculous antigens just as they do for syphilitic antigens. Furthermore guinea pigs may themselves be tuberculous and carry antibodies in their serum. The pigs should be killed and carefully examined for evidences of tuberculosis, and a control set up with each test to detect this possible source of error if present.

The reaction is unquestionably a true, specific antigen-antibody reaction. The antibody apparently differs from that responsible for the tuberculin reaction, as the latter is frequently present when the complement fixation test is negative. It has occurred to the author, however, that this may be due to a difference in the distribution of the antibody rather than to a difference in its nature. The antibodies recede after an active tuberculous lesion becomes quiescent and heals, and there comes a time when they disappear from the blood-stream altogether. A considerable portion, however, may remain fixed in the tissue cells as sessile amboceptors. It will be apparent that in such a case a complement fixation test made on the antibody-free blood would give a negative reaction, whereas a tuberculin test would find the sessile amboceptors available, either locally or liberated from their anchorage, and bring about a positive reaction. The difference is that the one reaction takes place in a test tube and the other in the body. This would also be true of those active cases in which the antibody production is so low as never to rise above the sessile level, leaving the blood stream practically free. The great value of the complement fixation test lies in the fact that it is positive only during and for a short period after an active tubercular process, in contradistinction to the tuberculin tests which may be positive for a long period, probably sometimes for life, after an individual has once been sensitized with the tubercular antigen.

The varying reactions, or lack of reactions, in different individuals and in different stages of the disease, can be better understood if one considers the immunologic conditions involved. The degree of an individual's immunity is determined by both local and general factors. It seems to me that immunologists have never laid sufficient stress on local resistance as a factor in defense which is in many cases equally, if not more, important than the general systemic defensive forces.

The degree of local resistance is determined by the strength of the resistance which the cells at the point of attempted invasion can exert against the invaders. In the case of pulmonary tuberculosis, these are the cells lining the respiratory tract, especially those of the tonsils, larynx, bronchi, bronchioles and alveolar spaces.

Individuals with adequate local and systemic immunity will remain free from tubercular infection and should always give a negative complement fixation test. If the local resistance is weakened or destroyed through some local intercurrent disease, a tubercular invasion may be effected; a systemic response ensues, accompanied by a production of antibodies, and the complement fixation test becomes positive. Such a case will, perhaps, never go on to the development of clinically demonstrable signs of the disease, because the general immunity mechanism is adequate and soon overcomes the infection. If in such an individual the general resistance is weakened in addition to the local resistance, the disease may make considerable inroads. During this time, while the general resistance is weak, there are few or no antibodies formed, and the complement fixation test is weak or negative. Cases in this class, however, usually reassert themselves, the immunity mechanism returning to normal, with a production of antibodies and positive complement fixation test.

Then there are persons whose local immunity is weak but whose general immunity mechanism is adequate. Such persons will not infrequently become infected but the infection is quickly overcome by the general systemic immunity mechanism. As the production of antibodies is a concomitant of the activity of this mechanism, a positive complement fixation test may be obtained dur-

ing this period. The clinical features of such a case will depend on the strength of the immunity response and the readiness with which it is elicited. The lesion may heal without any clinical signs, or it may develop all the clinical manifestations of tuberbulosis before the adequate immunity response has been developed. It is this class, I think, that is chiefly responsible for the positive reactions obtained in the non-symptomatic, non-clinical cases.

Individuals with adequate local but weak general resistance usually subdue the invaders at the portals of entry. They are infected with the usual frequency but, unless the local resistance breaks down, the infection is quickly overcome, because the local resisting power is adequate and the general immunity is not needed. These persons perhaps frequently develop tubercular processes (without exhibiting clinical signs), during which the complement fixation test is negative. If in such a case the local resistance for any reason becomes weakened the organisms may be permitted to pass to the deeper and less resistant structures and a rapid development of the tubercular process ensues, because there are neither local nor general immunity factors to check it. In these cases the complement fixation test will remain negative. It is conceivable, however, that sometimes the general immunity mechanism gradually increases in strength and the test then becomes positive.

Persons with weak local and weak general resistance will necessarily succumb to the disease early in life. In such cases the complement fixation test is negative during the course of the disease unless, as stated above, a general immunity gradually develops.

The divisions above outlined give, of course, the extremes, between which will be found all grades in the descent from adequate to weak. The degree of immunity stimulation is also dependent on the extent of the active lesions. Up to a certain point increased stimulation due to increased involvement is followed by an increased response. There may come a point, however, where the stimulation has become so great as to overwhelm the system and paralyze the immunity mechanism altogether. All these factors must be taken into consideration in attempting to explain the serological findings in different stages and in different individuals.

Attempts have been made to utilize the test for prognostic purposes. Only in connection with a careful consideration of the clinical progress of the disease can it be helpful in this regard. For instance, a strong complement fixation test may mean a moderate infection which is being quickly subdued, or it may indicate the acme of an immunity response to an intensive invasion to which the individual will soon surrender. A gradually weaking positive may mean that the case is closing up, or is going on to exhaustion. A case in which the complement fixation test has been positive should never be considered as closed until the test has become negative. In this way the test can become of considerable value in avoiding the premature discharge of patients from sanitaria or from medical observation.

It should be remembered that the complement fixation test merely indicates the presence or absence of antibodies which, in turn is determined entirely by immunity conditions. A positive complement fixation test means that a tubercular process is or has recently been active in the individual upon whose blood it was obtained, and that a general immunity mechanism was called into action with a production of sufficient antibodies to rise above the sessile level and appear in the blood stream. It has no relation whatever to the location of the process, its extent, and may have no direct relation to the symptoms for which the individual seeks medical advice. We can only say that a definitely positive complement fixation test means present or recent active tuberculosis. That such knowledge, when elicited, must be of inestimable value to the clinician is self-evident. It is also self-evident that because of information obtained from this test the clinician should not permit himself to relax in the slightest degree his usual close scrutiny into the family and personal history, his careful physical and roentgenological examinations. It is only in connection with competent clinical examinations that the test will make for better diagnoses. Without these it will make for worse. The physician who expects the complement fixation test to make his diagnosis for him will meet with disappointment. For instance, a patient with a tubercular adenitis may contract a bronchitis which has nothing to do with his tubercular process. He may give a positive complement fixation test which would mislead the careless physician into making a diagnosis of pulmonary tuberculosis. The test, like the Wassermann test for

syphilis, is of value only when carefully coordinated with other findings. It is but one additional, though valuable symptom at the disposal of the diagnostician, and the physician who fails to resort to it in doubtful cases is not giving his patient all he is entitled to.

I wish to express my sincere appreciation to Drs. Bellis, Cohn and Flancher of the Muirdale Sanitarium for Tuberculosis for their kind assistance, without which this work would have been impossible.

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Results of Complement Fixation Tests in Tubercular, Doubtful and Supposedly Non-Tubercular Individuals.

Classification		Total No.	Positive	Negative	% Positive
Incipient	Active	17	15	2	88.2
	Inactive	4	1	3	25.
	Total ...	21	16	5	76.1
Moderately Advanced	Active	37	33	4	89.1
	Inactive	13	1	12	7.6
	Total ...	50	34	16	68.
Far Advanced	Active	37	25	12	67.5
	Inactive	5	2	3	40.
	Total ...	42	27	15	64.2
Doubtful*		15	2	13	13.3
Supposedly† Non-Tubercular		236	24	212	10.1

*Cases with suspicious symptoms but in whom no definite clinical signs could be elicted, and in whom no definite symptoms subsequently developed.

†Cases with negative history and symptomotology, but not examined physically.

PATHOLOGY OF GLAUCOMA.*

BY CHARLES ZIMMERMANN, M. D., F. A. C. S.

MILWAUKEE.

In the just published Third Annual Report of the Ophthalmic Section of the Department of Public Health in Egypt by A. F. MacCallan, instead of 1.6 per cent of the regular statistics, 2.3 per cent among the patients seen in the Ophthalmic Hospitals in Egypt are said to suffer from glaucoma simplex, the small cornea of the Egyptians being supposed to predispose the eye to glaucoma. This is in accordance with the observations of Priestley Smith who found the cornea, as a rule, smaller in glaucomatous eyes, (at an average 11.1 mm. horizontally, 10.3 mm. vertically, against 11.6 mm. horizontally and 11 mm. vertically), than in non-glaucomatous eyes. Smith assumes that the smallness of the cornea predisposes to glaucoma by

*Read before the Milwaukee Oto-Ophthalmic Society, February 20, 1917.

the diminution of the perilenticular space through the resulting changes of position of the ciliary body.

The alterations of the *cornea* itself are caused by congestion or inflammation or both, and appear as edema due to increased transudation from the marginal vascular loops, subepithelial infiltration with lymphocytes, new formation of connective tissue and blood vessels, producing pannus glaucomatosus. Alt, (Centralbl. f. Aug., 1913, 217), found a glaucomatous pannus of the upper half of the cornea of half the thickness of the cornea, consisting of dense connective tissue with numerous blood vessels over Bowman's membrane, farther downward formation of blebs between the epithelium and the intact Bowman's membrane. As Fuchs showed, the edema of the superficial layers of the cornea may extend through the canals of the nerves penetrating Bowman's membrane under the epithelial covering and lift it up in form of blebs leading to keratitis bullosa. Besides cones of epithelial cells propagated into the new formed pannous membrane, nests of separated epithelial cells were found in it. They form the anatomical base for the small white spots, which may occasionally be noticed on the living cornea.

Descemet's membrane may show deposits containing albumen and fibrin, leucocytes and pigment. In hyprophthalmus the cornea is generally thinned, the opaque epithelium separated from it by fluid, and Descemet's membrane ruptured in consequence of hypertension, frequently showing pigment inclosures. They were first described by Haab who utilized them as differential diagnostic signs from megalocornea and cornea globosa. Recent investigations by Stähli, (Archiv. f. Aug., 79, 141), revealed that the ribbon shaped opacities are due to ruptures of Descemet's membrane and occur in more than three-fourths of all hydrophthalmic eyes. Hence they are a most valuable diagnostic sign of infantile glaucoma in later life, and the central opacities are a very important, so far neglected, element for the impairment of central vision, which Stähli found reduced to one-half or one-third. The ruptures are gaping by the receding edges and later filled with hyaloid substance form the endothelium and endothelogenous tissue from proliferation of the endothelia. These increase in number and form a massy cellular tissue with fine fibrillar and granular intercellular substance which is subject to secondary shrinking. Frequently the endothelia contain pigment from the ciliary body or iris.

In consequence of the increased tension the *sclera* shows general atrophy and subsequent diminution of elasticity. At the places of transit of the vessels cellular infiltrations of the vascular sheaths and the surrounding parts of the sclera have been observed. Heerfordt, (38 Ophth. Society, Heidelberg, 123, and von Graefe's Archiv., 83, 149), found in three eyes, affected with inflammatory glaucoma, the part of the wall of the scleral canal lying toward the sinus of the vortex veins intercepted by the blood current and bent into the opening of the scleral canal, so that it is obstructed the blood passage like a valve. He calls this part the sinoscleral plate and considers its formation as etiological factor in hemostatic glaucoma. Accordingly a congenital predisposition to acute inflammatory glaucoma consists in the thinness of this plate in connection with ectasia of the scleral canal, so that it can be easily mobilized. The predisposition may be acquired by laxity of the choroid, which makes a receding or superposition of the sinus possible. Congenital predisposition to chronic inflammatory glaucoma consists partly in predisposition to lymphostatic glaucoma, partly in congenital superposition of the sinus or ectatic venous branches.

Bartels, (Zeitschr. f. Aug., 14, pp. 103, 258, 458), concluded from his elaborate investigations that diseases of the *blood vessels* in glaucomatous eyes are very frequent, but mostly not beyond the scope of arteriosclerosis. They have nothing specific and nothing characteristic of glaucoma. There is no doubt that in glaucoma primary inflammatory changes of the blood vessels occur at the anterior segment of the globe and the central vessels of the optic nerve, but it is undecided, whether the observed changes are not exceptions. In Bartels' cases the narrowing of the intrascleral sections of the anterior ciliary arteries and the expansion of the posterior ciliary arteries were striking. The alterations found in glaucomatous eyes furnish no sufficient cause for rise of tension for any part of the eye. So far the estatic perforating anterior ciliary vessels which one occasionally sees in eyes suffering from old glaucoma, have been regarded as veins. Heerfordt, (v. Graefe's Archiv. 87, 494), showed that they are ectatic veins and arteries.

Löhlein, (von Graefe's Archiv. 83, p. 547), found in none of 20 different cases of primary

glaucoma, carefully examined with various chemical and biological methods, an increase in the *adrenalin content* of the blood serum and calls attention to the numerous possible errors in these examinations which had led Kleczkowski to directly opposite conclusions.

Obstruction of the *sinus of the anterior chamber*, through which the aqueous flows out from the eyeball into the canal of Schlemm, must necessarily augment the contents of the globe and raise the intraocular tension, if not otherwise regulating influences effect a compensation. First Knies and Weber showed the frequency and importance of the adherence of the periphery of the iris to the cornea in bringing about this condition. In accordance with this Priestley Smith, (Centralblatt f. Aug., 1913, p. 56), found adherence of the iris to the cribriform ligament or incarceration of the iris between this and the ciliary body in consequence of advancement and swelling of the lens. This occurs suddenly in acute glaucoma, gradually in chronic glaucoma. Ischreyt, (Archiv. f. Aug., 81, Bericht, 114), saw the same results from anterior adhesive iridocyclitis leading to adhesion of the root of the iris to the cornea without a special tissue between them, and Elschnig, (Klin. M. f. Aug., 56, 421, and Archiv. f. Aug., 81, Bericht, 114), presented anatomical examinations of 6 cases of adhesion of the intact anterior capsule of the lens to the posterior surface of the cornea and organization of the exudation lying between, the anterior chamber being very shallow. Mostly it is due to ruptures of the cornea with direct agglutination, or organization of the exudation. A congenital adherence of the iris to the cornea may be caused by fetal inflammation or disturbances of development. While the older authors attributed the congenital anterior and posterior synechiae to inflammations during intrauterine life, Peters, Makroski, Vossius, Seefelder, and E. von Hippel, assumed that the common portion of the cornea and pupillary membrane remained unseparated at different places. Böhm, (Klin. M. f. Aug., 52, 83, and Ophthalmology, Jan., 1915, p. 384), found changes in glaucomatous eyes of children, aged 4 and 8 years, indicating intraocular inflammations, in that of a child, aged 5, a typical arrest of development with subsequent ectasia of the eyeball.

The clinical diagnosis of a peripheral anterior synechia is of great importance, because iridectomy has a chance for a permanent result only if there is no firm adhesion between the root of the iris and the posterior wall of the cornea, as only then the purpose of the operation of liberating the normal efflux can be accomplished. Hesse, (Klin. M. f. Aug., 52, 464, and Ophthalmology, Oct., 1914, p. 143), therefore developed a new method of illumination, which allows a very good view of the extent of the anterior chamber. A direct proof of a synechia in primary glaucoma and in two cases of glaucoma with deep anterior chamber and enlarged eyeball, similar to primary hydrophthalmus, was excellently demonstrated by this method. Verhoeff, (C. Bl. f. Aug., Aug., April, 1913, p. 112), found in 10 cases of primary and secondary glaucoma sclerosis of the ligamentum pectinatum, i. e., a general thickening of the network of the ligament with new formed tissue on its surface, dependent on a preceding anterior synechia at the periphery which had been separated. The detachment was effected by the traction of the sphincter pupillae in the early cases, by cicatricial retraction of the atrophied iris tissue in the older cases. He says, however, that the etiological connection with glaucoma has still to be proved. Also Roenne, (Klin. m. f. Aug., 1913, October-November, and Centralblatt f. Aug., 1914, p. 211), observed in a typical case of glaucoma simplex sclerosis of the trabeculae of Fontana's spaces with deposits of pigment. Greeves, (Lancet, May 16, 1914, and Ophth., Oct., 1914, p. 127), described the invasion of the spaces of Fontana in or after iridocyclitis by granulation tissue containing capillary vessels, the tissue ultimately forming a solid mass of scar tissue, with which the pectinate ligament became incorporated. In another group of glaucoma cases the tissues of the pectinate ligament were unaltered, but the spaces were blocked by large swollen cells, apparently of phagocytic nature.

The *iris* may show foci of infiltration, inflammatory symptoms participating in the general inflammation of the whole uveal tract, and atrophy. Ectropium of the pupillary margin may follow from retraction of the organized inflammatory products on the surface of the iris toward the periphery, by which the pigment layer is exposed. The sphincter showed in all cases moderate or advanced atrophy. Often blood vessels may be seen distinctly in the atrophic tissue of the iris. Their walls show sclerotic changes. Very recently Koeppe, (Ophth. Society, Heidelberg, 1916, Arch. f. Aug., Bericht 81, p. 112), noticed with the

Nernst slit lamp of Gullstrand in 40 out of 50 cases of acute or chronic inflammatory primary glaucoma a more or less marked disintegration of the pigment epithelia and their descendent lump cells. It occurs as emigration of minute dark pigment in form of dust or coarse particles from the pigment cells, and transportation into the stroma of the iris, especially near the veins, the surface of the iris, the endothelium and the marginal portions of the cornea, to the anterior and posterior capsules of the lens, the aqueous, and the ciliary body, especially the lymphatic spaces and the adventitial lymphatic sheaths of the blood vessels. These phenomena may also be observed in healthy eyes, but they arouse the suspicion of impending glaucoma. The suspected specifity of this pigment distribution for glaucoma was verified in 5 cases, in which the early diagnosis of glaucoma was made from these pigment changes by the later clinical manifestation of glaucoma. Koeppe surmises that these changes may be of etiological importance for glaucoma simplex by obstructing and obliterating the lymph channels, leading to gradual decompensation of lymph circulation, a lymph stasis and the picture of lymphostatic glaucoma. This may develop into hemostatic glaucoma by participation of the walls of the capillaries and veins. From a sudden rise of blood pressure an acute attack of glaucoma may result. In concordance with Hamburger, Koeppe thinks that in the efferent paths of the anterior segment of the globe, besides the sinus of the anterior chamber, suction of the iris-sponge is of greatest importance.

The *aqueous* in glaucomatous eyes has been found especially abundant in albumen, and, as above mentioned, may contain pigment, and in consequence may be cloudy.

The *chorioid* and ciliary body may show swelling, hyperemia, exudation, edema, interstitial inflammation, cellular infiltration, and atrophy, changes which originally led von Graefe to the opinion that glaucoma was due to serous chorioiditis. The halo glaucomatosus was found to be due to atrophy of the chorioid with loss of pigment.

The *vitreous* in acute cases is opaque from infiltration with round cells and pigment, and may show admixture of blood and liquefaction, and in the stage of degeneration may have disappeared entirely and be converted into fibrillar tissue.

In glaucoma the *anterior chamber* generally is shallow. Löhlein's studies, (39 Meeting of Ophth. Soc., Heidelberg, 101), showed that primary glaucoma with deep anterior chamber has so far been observed only in young individuals, viz., in one-fifth of the cases of juvenile, not hydrophthalmic, glaucoma, mostly of glaucoma simplex, in another one-fifth the anterior chamber had normal depth. The eyes with juvenile glaucoma and deep anterior chamber generally show myopia, rarely emmetropia, never hypermetropia. Haag, (Klin. Mon. f. Aug., 54, p. 133, and Ophth. Oct. 1915, p. 122), reported on 67 cases of juvenile glaucoma with 111 glaucomatous eyes. Other pathological conditions, especially general disturbances of nutrition were very frequent. Inflammatory was twice as frequent as simple glaucoma. Thirty-one per cent occured in myopia, 17 per cent in myopia above 6 D., 28 per cent in hypermetropia. Hence a predisposition to glaucoma in hypermetropia does not exist, but in myopia. Deep anterior chamber was more frequent in simple than in inflammatory glaucoma and occurred almost exclusively in myopic eyes.

Hereditary elements were frequently observed. From Haag's material no relations could be deduced which justify the assertion of an essential difference of juvenile glaucoma from glaucoma of adults. Löhlein, (39th meeting of the Ophth. Society, Heidelberg, 1913, p. 97), sees in the combined hereditary transmission of juvenile glaucoma with high myopia a further support of the assumption of congenital hereditary anomalies in the structure of the eye. Out of 92 cases of juvenile glaucoma he found in more than 50 per cent formations due to arrest of development or congenital anomalies which in a portion of the cases proved to be directly or collaterally hereditary with the glaucoma, as persistent hyaloid artery, persistent pupillary membrane, anomalies of the retinal vessels, partial zonular cataract, coloboma of lens, iris and optic nerve, strikingly small or large corneal diameter, signs of microphthalmus, excessive hypermetropia, etc., anomalies of development that were also, although not as frequently, observed as accompanying changes, in congenital hydrophthalmus. Calhoun, (Jrl. Am. Medical Assoc., Jul. 18, 1914, Arch. f. Aug., Bericht 1916, p. 333), assumes that every case of glaucoma simplex under 30 years of age arouses the suspicion of heredity. Small size of the cornea and eyeball play an important rôle of general affections, perhaps gout

or rheumatism. Out of 16 members of a family 8 had glaucoma, 2 were suspected of glaucoma.

In his anatomical examinations of a large material of eyes, affected with primary and secondary glaucoma, Fleischer (38 Meeting of the Ophth. Soc., Heidelberg, 1913, p. 110) regularly found in the *optic nerve* the caverns of Schnabel, if the excavation was not too far advanced. At first they were microscopically small, in later stages the ocular end of the optic nerve was porous like a bath sponge, a regular skeleton from the loss of the nervous substance. According to Schnabel the caverns are a disease of the optic nerve specific of glaucoma, independent of increased intraocular tension, and the glaucomatous excavation is a consequence of the formation of caverns. That these changes are not specific of glaucoma has been shown by Axenfeld, Stock, and Fleischer, who also encountered them in highly myopic eyes. Fleischer found the cross section of the nerve in the area of the caverns enlarged, the pial sheath thinned and bulged into the intervaginal space. This can only be explained by the caverns being filled with fluid under considerable pressure. He therefore attributes the cause of the formation of caverns to imbibition of the optic nerve by a fluid in consequence of lymph stasis, which again is due to disturbances of circulation in this part of the nerve. The anatomical changes which led him to this view were the edema of the disc in the incipient stages of glaucoma, the greater affection of the axial portions of the nerve around the central vessels with loosening of the central fascicle of connective tissue, dilatation of the perivascular sheaths and the engorgement of the small vessels of the optic nerve. Clinically corresponded to this slight swelling and haziness of the disc in incipient glaucoma, thickening of the veins, perhaps also halo glaucomatosus, and the peculiarity of the glaucomatous visual field, showing an isolated involvement of certain parts of the nerve or single bundles, which can only be ascribed to the disease of single vascular territories. That a permanent lymph stasis may be followed by degeneration of the nervous elements, an excavation of the affected nerve bundles, and swelling of the nerve, is easily conceivable and is not without examples in the pathology of the central nervous system, e. g., certain forms of syringomyelia. The occurrence of these changes not only in primary, but also in secondary glaucoma proves that the formation of caverns cannot be a primary affection of the optic nerve independent of intraocular tension, as Schnabel maintained, but must be a secondary process in consequence of increased intraocular pressure. In lacunar formation in high myopia the cause of the disturbances of circulation must be sought, not in the pathological intraocular tension, but in general diseases of the circulatory apparatus, increased blood pressure, vascular sclerosis, etc. By this the possibility is given to explain the origin of the glaucomatous excavation in glaucoma simplex without rise of intraocular pressure. According to later anatomical investigations of Ischikawa, (v. Graefe's Arch. 87, p. 429), the first pathological changes of the nervous tissue in glaucoma commence in the nerve fibers of the intraocular and vascular portions of the optic nerve. They consist in swelling and dissolution of the nerve fibers. The swollen fibers may give the aspect of incipient caverns of Schnabel. The same changes occur regularly in the nerve fibers of the retina. The fluid which after the disintegration of the nerve fibers fills the lacunae, prevents the contraction or vicariating proliferation of the remaining glia and connective tissue. Later on also these tissues disappear and the caverns result. The causes of this degeneration of the nerve fibers probably is, in connection with the increased tension, a qualitative alteration of the ocular fluids, which leads to the autolysis of the nerve fibers, the glia, and connective tissue. The glaucomatous excavation is exclusively the consequence of the glaucomatous nervous degeneration, characterized by the formation of lacunae in the nerve bundles. Gilbert, (39 Ophth. Soc., Heidelberg, p. 342), also emphasizes the importance of disturbances of circulation for the genesis of the caverns. In a series of cases of primary glaucoma he found such near topic relations between recent hemorrhages and the formation of small caverns, that he does not doubt that the caverns may also be caused by hemorrhages.

The depth of the excavation varies from 0.6 to 1.50 mm. and occasionally more. I brought you here a microscopic slide, which you also can see well macroscopically, of an excavation measuring 2 mm. in depth. It is from the eye of a woman, whom I first saw in 1911 suffering intense pain from absolute glaucoma in both eyes which were blind. This was relieved by treatment and the patient regained a little sight in the left eye. In October, 1914, she came again with ulceration and

abscess of the right cornea, which necessitated enucleation.

Behr, (Klin. Mon. f. Aug., 52, June, 1914, p. 790, and Ophth., April, 1915, 579), reported the anatomical examinations of two cases, in which the excavation, caused by the displacement of the lamina cribrosa backward, was filled in by tissue. From these cases and a review of literature B. distinguishes three characteristic types: The first shows the properties of gliosis. It consists in a more or less energetic proliferation of the glia tissue (cells and fibers), and new formation of numerous vessels with thickened walls. The proliferation may be so excessive, that not only the excavation is completely filled by it and that it spreads into the layer of nerve fibers of the retina, but that the tissue bulges like a mushroom into the vitreous and resembles choked disc. Besides these active proliferations also hyaline degeneration and formation of cysts may be found. Occasionally gliosis may be combined with inflammatory changes, which perhaps are identical with the still unknown primary cause of inflammatory glaucoma. Nothing definite is known of the etiology of this gliosis.

The second group comprises cases in which the greater portion of the nerve fibers has escaped atrophy. The papillary tissue on the lamina cribrosa is loosened by small-celled infiltration and inflammatory edema, filling the excavation completely. B. thinks it probable that the affections also in these cases is due to proliferation of glia, before the inflammatory alteratoins set in. Possibly these cases represent an incipient stage of the first group from which they differ by the presence of numerons nerve fibers and inflammatory elements.

While in these two groups the disappearance of the glaucomatous excavation by proliferation of tissue takes place under persisting increased tension, in the third gronp an operative restitution of normal intraocular tension revives and loosens the compressed tissue of the disc, sometimes under edematous phenomena, and the retrocession of the lamina cribrosa decreases more or less. In these cases the complete restoration of the normal level of the disc is exceptional. Its persistence depends upon the endurance of the diminution of tension.

As you will have noticed, I did not aim in this brief survey at a complete enumeration of everything that has been published on the pathology of glaucoma, and which you may find in the text books, but confined myself to the utilization of the important points of the literature of the last five years, as I thought this was what you would wish to hear.

THE EYE IN ITS RELATION TO CONSTITUTIONAL DISEASES.*

E. H. BROOKS, M. D.,

APPLETON.

Having received a preemptory order from our efficient secretary to prepare something of scientific interest to present at this meeting, the task of selecting some topic that might be of general interest to surgeon, internist, obstetrician, gynecologist, oculist, or any person who may be endeavoring to cling to any *combination* of the many subdivisions of the thankless, sleepless, wheatless, seatless task of trying to serve humanity in the field of medical strife, my endeavors have found favor in the "window of the soul" which seems to furnish a link in the chain of common interest to all physicians alike.

Probably as large a number of general pathological conditions find expression, or reflection of more or less diagnostic significance in the human eye as in any other one organ, and for this reason I have hoped that we may spend with profit the short space of time allotted for the presentation and discussion of a special subject, with borderline interests. The subject as announced however would furnish a field whose scope would be so broad that it would be impossible to more than enter it at a single meeting so I have concluded to confine my text to a few pathological *retinal* findings as they relate to general constitutional diseases and even this subdivision we can hope only to touch upon.

In consideration of the structural formation of the retina it will suffice to recall that it is extremely delicate, thin and transparent with a purplish red color traversed by radiating retinal arteries and veins which find common outlet in the sheath of the optic nerve, which in turn enters the globe at its posterior poll and by expansion of the nerve creates the sensitive retina. After leaving the nerve margins upon its entrance into the eye

*Read before the Outagamie County Medical Society.

the retina is held in suspension (unattached) by the vitreous humor and is unmarked, other than by the maculae lutea until it becomes attached in the anterior segment at the ciliary processes.

While the inner surface of the retina is supported by the vitreous body-counter pressure is afforded by the choroidal coat which we will observe is many times simultaneously affected with the retina in varying pathological retinal changes.

The retinal construction is both nervous and supporting in character but during the activity of some forms of disease the nervous element may be entirely absorbed, leaving only the supporting substance, and also it is well in this connection to mention that because of the retinal blood vessels being of a terminal character that, in the event of their destruction, there can be no establishment of collateral circulation and consequently there is rapid development of atrophic areas.

Any condition causing retinal irritation will usually be made manifest by a slight initial swelling and irritation around the nerve margin. This is calculated to be explained because of the slight crest at the commencement of the spread of the nerve fibers, and from simple, almost unrecognizable congestion, there may be developed all gradations of inflammation, manifest by distended vessels, hemorrhages, infiltration oedema, and in later stages large patches of white or gray atrophic spots and as naturally follows from process of deduction, impairment of vision is in direct proportion to the extent of the envolvement, and subsequent degeneration, varying from slight visual impairment and small scatoma areas to *serious* destruction and sometimes to total loss of sight.

Almost any abnormal condition of the human system, may as I have previously stated, find its reflection in the retina, manifest by greater or lesser disturbance of vision. *Albuminuria* should probably be classed as foremost in the ranks of general involvement causing ocular disturbance as I find that it is a pretty general opinion of recognized authority in ophthalmic literature that of all cases of retinal inflammation 30 per cent of such cases are due to albuminuria. Beside being the most frequent cause of retinitis the disturbances caused by albuminuria furnish the best characterized *making* of any of the other forms of retinitis, and because of this fact and the fact also of degenerative changes taking place *early* in this condition it is made possible for the oculist to frequently make a diagnosis of acute Brights disease before it is possible to demonstrate the presence of albumine in the urine. This however is not *always* possible. In these cases where there has been a spot of suggestive disturbance revealed to the oculist it is quite necessary that frequent, repeated urinalysis be made as it has to my certain knowledge required seventeen urine analysis extending over a period of twelve weeks to find albumine, in a case when the fundus findings were so convincing as to be almost diagnostic and which proved to us the necessity of persistence in these analysis.

The severity of the retinitis seldom bears any direct relation to the nephritis. While the nephritis may improve even to a point approaching total absence of albumine, the vision may grow gradually worse until the patient becomes nearly if not quite helpless; on the other hand quantitive analysis may show an ever increasing quantity of albumine and the visual power remain unchanged or there may be transient improvement. While the retinal makings of albuminuric retinitis are the most characteristic of any of the forma of retinitis, there is a greatly varying ophthalmoscopic picture during the progressive stages of the inflammation and atrophy, with the earlier symptoms showing as slight swelling of the optic nerve and possibly accompanying small, diffuse spots of hemorrhage from the smaller arteries and then increasing in intensity the more advanced changes will be evidenced by greatly distended, distarted and broken vessels, with accompanying hemorrhages of varying size and form and these associated with large white patches in the region of the papillae and maculae, showing the white radiating striae in the macular region with a speckled zone surrounding the head of the optic nerve.

Any form of kidney disease may be directly responsible for an active retinitis but there is no form of retinitis due to nephritis which is as common as that of the atrophic kidney. Brain tumors, diabetis, and arterosclerosis may present strikingly similar changes in the retina but in confusing instances the totality of the symptoms, blood and urine analysis will assist in making the differential diagnosis.

A positive diagnosis of albuminuric retinitis carries with it a decidedly evil prognostic significance as the time limit before a fatal termination under such circumstances generally does not exceed a period of five years. There have been some cases

recorded of sudden total blindness in nephritic subjects where ophthalmoscopic examination would reveal no fundus changes and these cases known as transitory blindness, and which are usually accompanied by nausea, headache, vomiting dyspoea and loss of consciousness, in short, a typical picture of *uraemia* develop the most exaggerated eye symptom in the course of a few days and almost invariably make as rapid a recovery as eliminative treatment clears away the uraemia. In these cases it may be noted that the pupillary reaction is preserved which demonstrated that the lesion is located deeper than the eye itself and that the symptoms are due to cerebral toxemia. This sudden complete blindness known as Urenic Amaurosis is differentiated from the typical Albuminuric retinitis in that the latter is slow in its onset, seldom goes on to complete destruction of sight and when the sight is lost it cannot be restored.

L. Webster Fox, professor of the Medical Surgical Hospital of Philadelphia, in making his deductions from the study of 6,000 cases in his clinic during the years 1900, 1901 and 1902, classifies the ocular conditions which may arise in the course of nephritis as follows:

1. Complete blindness unassociated with visible ocular changes—Uraemic Amaurosis.

2. Retinitis and neuro retinitis of a type peculiar to chronic nephritic disease.

3. Alterations in the caliber and relations to the retinal blood vessels. Hemorrhages and exedate may or may not be present or may occur without changes in the visul wall.

4. The Uvae may undergo mixed alterations—manifesting themselves largely by changes in the iris and choroid.

5. Lenticular opacities.

6. Impairment of function. Palsy of the extra ocular muscles, particularly the superior oblique and external rectus.

7. Recurring conjunctival hemorrhages. These usually occur during the night and are discovered by the patient or some member of the family in the morning. Some observers consider these slight superficial hemorrhages as an actual indication of existing kidney disease but in the opinion of Prof. Fox the condition is a premonitory symptom of kidney disease being associated with generalized disease of the arterial wall. This condition giving rise to kidney affection.

Retinal markings in the *diabetic* patient may not be unlike in many respects, those found and just previously described under albuminuric retinitis. When a suggestive retinitis falls short in diagnostic features—general symptoms so commonly known to diabetes must establish the diagnosis. A *preliminary* diagnosis of diabetic retinitis is seldom made by ophthalmoscopic examination.

Diabetic retinitis is more inclined to be associated with choroidal conditions, however we not infrequently come in contact with extensive choroidal changes in albuminuric retinitis. I have at the present time treating a case of diabetic retinitis of long standing whose vision has been reduced to counting fingers with the right eye while the left eye has progressed to a state of total blindness.

Brilliant white spots, located for the most part in the macular region, characterizes this form of retinitis but distinction between this and other forms of retinitis may not always be made by ophthalmoscopic findings, but the careful urine analysis is convincing. Usually the amount of vision to be regained is nil and extensive destruction has generally preceded any complaint of the patient regarding failing vision, but in contrast to the albuminuric retinal involvement which has already been noted to bear no direct relation of the severity of the eye disease to the kidney involvement or vise versa, the outlook in diabetic retinitis becomes more favorable in proportion to the degree in which the diabetes can be controlled.

Systemic ravages of *syphilitic* infection do not in their relentless destruction pass unnoticed the orbital contents. Prof. Alexander claims to have demonstrated that in 8 per cent of all cases of syphilis that retinitis develops and that it may be due to either hereditary or acquired syphilis and when resulting from the acquired form it may make its appearance in from one to two years following the date of the infection. The eye symptoms during the onset of syphilitic retinitis closely resemble those of albuminuric retinitis, with similar retinal markings. There are fewer retinal hemorrhages and those that do occur are much smaller, but an accompanying choroidal inflammation and an active destructive iritis are decidedly more frequent and are valuable diagnostic aids. Beside the diminished vision which is an inevitable symptom in all forms of retinitis, there are two especial or peculiar symptoms usually asso-

ciated with specific retinitis and these appear in the form of night blindness and a peculiar shimmering of the light. This latter symptom may be so extreme as to drive the patient to a point of nervous frenzy.

Local treatment avails little in these cases and the administration of the acknowledged syphilitic remedies will control the local eye conditions and ultimate influence upon the sight of the patient must be in proportion to scar tissue left in the path of the destructive process.

Mauthner says that "when no other cause can be ascertained for retinitis the diagnosis of syphilitic retinitis should be made," but we should always make further confirmation of the diagnosis in actual syphilitic lesions in other parts of the body and also by the process of elimination—doing away with the possibility of other causes.

In syphilitic retinitis we have the gratifying knowledge that the vision generally improves during the course of properly directed general treatment. Complete restoration of vision can scarcely be expected in these cases however but in a general way the prognosis is much more favorable than in the albuminuric retinitis, however the greater tendency for recurrence together with greater liability of involvement of the allied structures adds to the toll of syphilis many cases annually of greatly impaired vision and some of total blindness.

While hemorrhages occur in *special* forms of retinitis to a greater or lesser degree, and manifest some features, recognizable as differentiating phases *in* these *special* forms we are occasionally brought in contact with retinal hemorrhages which cover nearly if not quite the total retinal field covering all general markings and to these conditions the name naturally of hemorrhagic retinitis is given. Hemorrhagic retinitis may be the result of any of the depleting general diseases. The ophthalmoscope in these cases shows numerous flaring hemorrhagic patches and by the use of this instrument in successive examinations, small fresh hemorrhages will be observed. This condition is usually unilateral but in case of an involvement in both eyes the involvement in the one would be much more extensive than in the other. Berry says that atrophic changes usually take place after some time so that although the hemorrhages may clear away leaving often little or no trace of their existence, the vessels become narrowed and obliterated, the disc pale and the field of vision concentrically limited just as in atrophy of the optic nerve until eventually the vision is completely lost. Examination of the fundus may reveal a hemorrhage situated *on* the retina and which because of its not being associated *in* the retinal substance usually is absorbed and leaves no evidence of its having existed and vision in these cases almost invariably returns to normal.

Aneurism, endarteriris, atheroma, hypertrophy of the left ventrical are all ascribed as causes for these hemorrhages as also are in the new born (with difficult labors) pupura, scurvy, haemophilia, anemia, thrombosis of central retinal vein, conditions of the blood in which the individual blood cell is pathologic. The diagnosis is made by the ophthalmoscope after the patients complain of amblyopia. The prognosis in this form of retinitis depends upon the extent and location of the hemorrhage and should there be involvement of the maculae lutea, serious impairment of vision is sure to follow, while an extravocation of the blood into the vitreous humor may bring about an increased tension which often results in one of the most serious forms of glaucoma.

A form of retinitis due to the presence of a pyogenic organism which gains access to the retina through a penetrating wound, or is carried by septic emboli is known as purulent retinitis and is characterized by whitish areas of fatty degeneration and suppuration in the macular region. Whatever the course of infection or the method of communication to the retina of the micro organisms the culmination of this form of retinitis almost invariably calls for enucleation, as panophthalmitis is inevitable with general symptoms so severe that a fatal termination is not improbable.

Leuchaemia and anemia as may be expected through their influence on the general circulation create retinal changes peculiar to these conditions but which conditions present no typical or diagnostic signs other than the general paleness and lack of nourishment which is evident by ophthalmoscopic examination but the blood analysis is the real diagnostic factor in this form of retinitis, which is so slow in its progress that we are usually able to correct or control the advance of the existing general trouble sufficiently early to prevent much retinal destruction and therefore we seldom see much loss of vision from these forms of retinitis.

Gouty retinitis, retinitis circinati, retinitis stri-

atae, retinitis proliferans, retinitis punctate centralis, are uncommon forms of retinitis that are occasionally met with in clinical practice and as only the former bears any direct interest to the subject we will accept the respective names as sufficiently descriptive and pass on to a brief consideration of the associated pathology and in such consideration I am sure it is not necessary for me to disclaim originality. In the translations of Prof. Ernest Fuchs, 12th Edition, Copyright 1911, he says, "In addition to the poisons that are brought into it the body is also harmed by those which it itself produces. A transition form between the introduced and the self produced poisons are those which are developed in the digestive canal by abnormal processes of decomposition from nutrient materials which have been introduced there and are not in themselves toxic. By some, the cause of many diseases has been regarded as consisting in such intestinal auto intoxications. Hitherto however very few facts have been surely demonstrated, and intestinal intoxication is much too often forced to serve as a convenient aetiolgy for the most varying diseases. Better established and longest known, is the etiologic part played by the metabolic diseases proper like gout, diabeted, etc. (E. G., the iritis and retinitis in case of the eye) is still obscure.

Many diseases of individual organs lead to diseases of the eye which not infrequently are the first thing that directs the attention of the physician to the casual affections. It is an acquisition of most recent times to have recognized that in many cases these inter relations depend upon altered chemical action. We owe this knowledge in part to the discovery of the function of the glands which possess an interior secretion; diseases can be caused both by the increase of this secretion above the normal and by its cessation. Again, examination with sera has shown how by utilizing the round about passage through another animal we can study the interchange of action in the organs of the same body. In this way it has been demonstrated that diseased organs can deposit in the blood the products of their metabolism or their decomposition which cause, almost like a chemical reaction, definite changes in other organs or tissues. Here is still a wide field for investigation lying before us.

While it is only a rare occurrence that we have to do with diseases of the eye that result from secretory disturbances in the glands having an interior secretion, cases are very frequent in which the eye, owing to chemical influence is implicated in disease of other organs.

The most frequent case of this sort (equally important for the ophthalmalogist and internist) is the inflammation of the retina occurring in nephritis. Up to a short time ago the connection between the two has been sought for in vascular changes or in the increase in blood pressure, conditions which both usually accompany nephritis, or it has been supposed to consist in the retention in the body of sodium chloride due to its insufficient excretion by the kidneys. Although these factors cannot be altogether disregarded probably the main injury to the retina is done by toxic matter which is formed by the decomposition of kidney substance and which possesses a particular affinity for the tissue of the retina. That the retina too is diseased is due to the fact that the retina has one or two kinds of albumine which it possesses in common with the kidneys and which therefore are attacked by the nephrotoxine. That the metabolic products of the normal kidney do not injure the retina of the same animal presupposes that the organs of one and the same body (or of another individual of the same species) are immune to its own metabolic products. But when there is disease of an organ with disintegration of tissue, this immunity may not suffice.

Diseases of the eye sometimes develop not only as a result of diseases of individual organs, but also in consequence of *physiological* processes taking place in them. As an example may be adduced the inflammation of the optic nerve which sometimes occurs in the course of pregnancy or lactation without there being any demonstrable diseases of the body. It is conjectured that in this case also the fault lies with the action of toxins which either have been formed as an exceptional thing in the course of the physiological processes occurring in the organs concerned or toward which the eye does not possess its normal immunity, and passing from this opinion of one of our best recognized authorities to the new splendid work of Dr. Arnold Knapp of New York City, the first sentence in the paragraph under the heading of pathology reads, "A definite explanation of the connection between nephritis and retinitis cannot be given." There are apparently two factors present, disease of the blood vessels and the altered condi-

tion of the blood; sclerosed vessels may be secondary to the latter condition or a part of a general augiosclerosis.

Accordingly, two forms of albuminuric retinitis can be distinguished. (1) When the altered blood condition is responsible, causing the acute nephritis, as after scarlet fever and pregnancy. (2) When the general arteriosclerosis causes the chronic nephritis. The changes in the vessels which occur in these cases were particularly studied by Michel and Karl Theodor, and all changes were made dependent upon this cause, so that Michael believed that the retinitis did not follow nephritis but that both were produced by a common cause, resting in changes in the vessels. Leber believes that the changes in the small retinal vessels in nephritis retinitis can no longer be regarded as the cause, as these same changes in the retina have been observed with normal vessels, and the vascular changes are different, as the retinal affection is acute or chronic.

Elsching of Vienna examined about 200 cases of nephritis. In these a nephritic retinitis of various grades was found present in 32 per cent of the cases. In the remaining 67 per cent in more than oen-half the vessels were normal, and slight arteriosclerosis was present in 44 per cent. The changes were in general of very slight dgree. There was never marked or extensive narrowing or cloudiness of the arteries. And in the cases of albuminuric retinitis in only a small part where the process was particularly severe were marked vascular changes present. The direct influence of nephritis in the causation of changes in the retinal vessels is probably very slight. The changes in the retinal vessels found in cases where a nephritic retinitis has not developed are probably not the result of the nephritis, but an associated general arteriosclerosis.

Opin and Rachon Duvigneaud are also opposed to this vascular theory and Shieck showed the inconsistency of the vessel changes. Rachon Duvigneaud is sharply opposed to the view that a common cause affects the vessels in both kidney and retina equally. Opin and his investigations have shown that in nephritis no organs are affected except the kidney, retina, and hypertrophied heart, and that there is no generalized vascular affection. The distinction between a retinitis secondary to a primary nephritis with changes in the blood (Somelsohn and Weeks) and a retinitis from general vascular disease is too arbitrary in his opinion. Some authors believe there is a nacl and urea retention in nephritis and a *pathologic* increase of urea in the blood.

Moore suggests that there are two factors responsible for retinal changes in renal retinitis, the one vascular and the other toxic of which either gives characteristic changes. Thus in the chronic parenchematous nephritis the toxic element is much more prominent than the vascular one. The blood pressure is not raised and the retinal changes consist in many areas of white exudation in the tissues of the retina, often accompanied with oedema of the retina which may be so great as to lead to detachment. Retinal hemorrhages are not plentiful and the usual star figure is not characteristic and the star figure in the maculae is generally present. Both factors may enter into the causation of a particular case.

With these diversified opinions, gleaned from laboratories and dissecting rooms which have for many years furnished the material for research to the men best known as authorities in the field of ophthalmology it is evident that the leaves of learning must many times be turned and many new pages written, ere we will become possessed of a definite knowledge of the pathological relations of these serious kindred diseases.

BOOK REVIEWS

THE TREATMENT OF CAVERNOUS AND PLEXIFORM ANGIOMATA BY THE INJECTION OF BOILING WATER. Wyeth Method. By Francis Reder, M. D., F. A. C. S. C. V. Mosby Co., St. Louis, Mo.

Is a small book of seventy-three pages, containing a number of case reports with illustrations before and after treatment, and a very admirable and lucid description of the technic of the method, which was employed in one hundred and four cases without failure.

The author states, "A cavernous or plexiform, especially of large size, in one of the most difficult lesions with which the surgeon has to contend. In fact, some of these lesions are looked upon as inoperable and have been abandoned to an ever increasing deformity and discomfort," which is undoubtedly true and is sufficient excuse for the author's efforts and the surgeon's familiarity with the method.

This method is not indicated in cases of nevus. Dr. Reder says, "The treatment of a nevus has proved more or less unsatisfactory to me no matter what method I employed."

The publication of monographs such as this would seem to be a most desirable innovation which we hope will meet with sufficient approval to warrant repitition.

F. G. C.

Medical Ophthalmology. Arnold Knapp, M. D., New York. Professor of Ophthalmology, Columbia University, Executive Surgeon, Herman Knapp Memorial Eye Hospital. A volume of an International System of Ophthalmic Practice, edited by Walter L. Pyle, M. D., Philadelphia. 509 pages, 32 illustrations. Philadelphia. P. Blakiston's Son and Co., 1012 Walnut Street. 1918. Price, $4.00.

We take great pleasure in bringing this important book to the knowledge of our readers, as it deals with a subject in which the eye specialist and the general practitioner are interested alike. "Ophthalmology has relations, closer or remote, with every branch of medicine and surgery; indeed, with almost every branch of science." It has been the aim of the author to give the essential of what is known of these relations at the present day. In this he has succeeded very well. The chapter on ocular affections in diseases of the nervous system is preceded by an excellent exposé on introductory anatomy and physiology of the nervous system with regard to vision, with tographical diagnosis, which will be especially welcome as it will not be found elsewhere in this succinct and complete form. Then follow the sections on diseases of glands with internal secretion, poisons, infectious diseases, diseases of circulation, respiratory and digestive tracts, anemia, diabetes, diseases of the kidneys, female organs, bones, skin, and hereditary diseases.

The author has freely drawn on the larger works, mentioned in the preface, and quoted at the respective places. Although we find his own views expressed, he also presents discrepant opinions, enabling the reader by frequent references to find the sources for more extensive study. As there exists no book in the English language on the relations of eye affections to other diseases in such completeness, the author has filled an actual want. His clear style and the practical arrangement of the matter will ensure to the valuable work a large circulation. It has our highest recommendation.

C. Z.

Automobile Map of Wisconsin. This is a splendid map covering a radius of one hundred miles northwest and south of Milwaukee. It shows counties, cities, villages, summer resorts, lakes, wagon roads, railroads, electric lines and in red ink the authentic and official auto roads with complete indexes to all references. We can recommend this map. Price on paper $1.00, cloth $2.00. Published by C. N. Casper Company, 454 East Water Street, Milwaukee.

Diseases of the Male Urethra. By Irvin S. Koll, M. D., Professor of Genito-Urinary Diseases, Post-Graduate Medical School and Hospital, Chicago, Octavo of 151 pages, with 123 illustrations, several in colors. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $3.00 net.

This is an excellent work on the subject. It is concise, clear and simple. The book is published on a high grade of paper and the many illustrations, nearly all of which are original, were taken from the author's clinic at the post-graduate medical school, Chicago. The subject of gonorrhea is thoroughly covered in the first nine chapters. Then other pathological conditions of the urethra are taken up with a final chapter on Sexual Impotence and Sterility each. This work is a most valuable contribution to the subject and we have seldom seen a better example of the book-making art.

Clinical Diagnosis. Fourth edition, revised and reset. A Manual of Laboratory Methods. By James Campbell Todd, M. D., Professor of Pathology, University of Colorado. Fourth edition, revised and reset. 12mo of 687 pages with 232 text-illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1918, Philadelphia and London. Cloth, $3.00 net.

This book offers a clear and concise statement of laboratory methods which have clinical value with a brief guide to the interpretation of results. It will be found of special value to the student and practitioner rather than the trained laboratory worker. The author believes that as much good can be learned from a good picture as from description and special attention has been given to the illustrations, which are equal if not better, than any manual of its kind we have seen. The whole field of laboratory work is covered and special chapters are devoted to the preparation and use of vaccines and serodiagnostic methods.

The Hospital as a Social Agent in the Community. By Lucy C. Catlin, R. N., Director of Social Service Work and Executive Director of the Out-Patient Departments of Youngstown Hospital, Ohio. 12mo of 113 pages, illustrated. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $1.25 net.

This work is especially intended for social workers in the new field of Hospital work in smaller cities. It will be found a most valuable contribution to the subject by those engaged in this work and should stimulate an interest in establishing such a department in communities of any size supporting a hospital without a social service department. The general subject of social service, the relation to and co-relation with other social agencies, the out patient departments and the advantage of establishing them on a social service basis are well covered. Case histories are quoted to illustrate points made and the various blanks and forms used in the work are incorporated in an appendix.

Qualitative Chemical Analysis. (Second Edition.) A Laboratory Manual of Qualitative Chemical Analysis. By A. R. Bliss, Jr., M. D., Ph. G., Professor of Pharmacology, School of Medicine, Emory University, Atlanta, Ga., formerly Professor of Chemistry and Pharmacology, Graduate School of Medicine, University of Alabama. Revised and Reset. 194 pages, with working tables. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $2.25 net.

The first edition of this work has been completely and thoroughly revised. It is intended as a manual for the beginner in analytical chemistry but the work presupposes that the student has already a fair knowledge of the fundamental principles of the physical and chemical theory.

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L. M. WARFIELD, M. D., Editor
79 Wisconsin Street, Milwaukee

J. P. McMAHON, M. D., Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:
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EDITORIALS

IMPORTANT NOTICE!

THE managing editor of the Journal is experiencing great difficulty in mailing the Journal to men in the Medical Reserve Corps called into active service. The number of journals returned each month because of lack of proper address is increasing to such an extent as to make necessary a change in mailing rules.

The cost of publishing the Journal is now about 12c per copy. It is therefore easily understood that a useless and increasing expense to the Society can be avoided by insisting that the editorial office be supplied with a correct mailing address.

We are extremely anxious to have the Journal reach each enlisted man and we appeal to all members in the service to advise us at once as to their address and immediately notify us of any change. Beginning with the September issue, it will be necessary to take from the mailing list the names of all men in the service whose address has not been sent to us. If you do not receive the Journal after this issue you will know the reason. Please at once, without delay, send us your mailing address and keep us advised of any changes.

HYPERTHYROIDISM IN THE DRAFTED MEN.

WE are led to believe that many of the rejections at the camps among the men who are sent by local examiners are due to conditions which might have been recognized at the time of the original examination. Quite a number of men are victims of that badly named condition, hyperthyroidism. Many of the men have frank signs and even some symptoms of Graves' disease. It would seem to be a safe rule for the guidance of examiners to look with suspicion on any man whose pulse rate while quietly seated is above 84 beats per minute. Of course there will be cases of simple tachycardia in which it may be difficult to tell at the first examination whether they are of no moment or whether they are truly due to disease. In general, simple tachycardia may be differentiated from that of hyperthyroidism by asking the applicant to take a full breath, hold it for a few seconds, then exhale and hold the breath for a few seconds. He then breathes naturally. The pulse rate at once slows to the usual normal rate and does not return to the rapid rate provided the increased rate be due to simple excitement. If with this simple method the rate is not reduced, then signs of Graves' disease should be carefully looked for. Even the very mildest forms of Graves' disease are not qualified for military service. Experience at all camps abundantly confirms this statement.

The signs to look for particularly are, tachycardia which increases by mild exercise out of all proportion to the exercise and the pulse rate continues rapid long after the man is quiet; tremor of the extended fingers; lagging of the eyelids when the man is told to follow the examiner's finger from above down without moving his head; inability to hold the eyes converged when the tip of the finger is gradually brought towards the bridge of the nose. Exophthalmos may or may not be present. It is not at all necessary for the diagnosis. Enlarge-

ment of the thyroid may or may not be present. This also is not necessary for the diagnosis.

These men with unstable vasomotor control have been found to break down very soon after coming to camp. A most important point to remember is that these men may give a history of doing a full day's work every day. As long as these men do only the routine daily toil they manage to get along without symptoms, but as soon as the system is called upon to exert itself in some unusual way, there is no reserve force, exhaustion feelings, palpitation, dizziness, come on and the man drops out. He is no good to the Army or to himself.

It is hoped that the examiners on the local boards will bear these few points in mind. It will save time and money both to the men and to the Government.

ONE OF OUR DUTIES.

THE National Security League, acting through its Congressional Committee, is making a country-wide endeavor to stimulate the people of every state to demand that the candidates of both parties for Congress shall be men of eminent capability as well as of undoubted loyalty. Too little attention has been paid in the past by the public and especially by members of our profession to the proper selection of our law makers. The recent failure of some of our Wisconsin representatives to support legislation of such importance as the Owen Bill and on the other hand the unwarranted support given such vicious legislation as the Bill to force osteopaths on the Surgeon General by men whom we, in Wisconsin, have elected to office, should awaken in every physician a realization of the importance of knowing something of the man whom we vote into a legislative office. The record of some of our present congressmen for instance on these bills of such importance to public welfare, and their record on War Legislation should be remembered in the primaries next month.

The next Congress of the United States will be required to deal with many internal and international questions which fundamentally effect the welfare of the country and of the world. It is vitally necessary that all patriotic Americans take active steps toward insuring the nomination in their respective congressional districts of men who by their high order of ability and character, as well as their undoubted loyalty, are eminently qualified to deal with the tremendous problems which are facing the country. If you are a practical patriot, show an active interest in these matters, get your friends to do the same thing, join with others in an effort to get the right men to file nominating petitions in due time before the primaries. Go to the primaries and vote for the right men.

The day of the typical American political policy of "Let George Do It" should once for all be ended. Are the only Americans who can do their duty, those who are offering their lives in the trenches, on the seas or in the air, or are there left at home enough patriots of the active, as distinguished from the merely vocal, sort, to do their duty in this crisis by giving the nation and its precious lives now or to be in service, the adequate guidance and stewardship which can only be supplied by an eminently capable Congress?

PRESIDENT WILSON INDORSES OBJECT OF MARQUETTE DRIVE

THE WHITE HOUSE
WASHINGTON

1 July, 1918.

My dear Mr. Nieman:

Your letter concerning the School of Medicine of the Marquette University gives me an opportunity to express, as the Medical Advisory Commission of the Council of National Defense has repeatedly expressed, a very deep interest in the maintenance of our medical schools. It is of capital importance to the country that they should be maintained at as high a degree of efficiency as possible. Never before did the nation need so large a number of thoroughly trained physicians and surgeons.

Cordially and sincerely yours,

Woodrow Wilson

Mr. L. W. Nieman,
Marquette-Medical-School,
Endowment Fund,
Milwaukee, Wisconsin.

PRESIDENT WILSON'S WARNING.

"This war is one of nations—not one of armies—and all our one hundred million people must be economically and industrially adjusted to war conditions if this nation is to play its full part in the

conflict. The problem before us is not, primarily, a financial problem, but rather a problem of increased productions of war essentials and the saving of the materials and the labor necessary for the support and equipment of our army and our navy. Thoughtless expenditure of money for nonessentials uses up the labor of men, the products of the farms, the mines and factories, and overburdens transportation, all of which must be used to the utmost and at their best for war purposes."

BETWEEN LOANS.

The blossoms whiten the valley bed,
The robins sing in the apple-tree;
And after all is done and said,
This grim old world looks good to me.

The service call will sound again,
The din of the battle will never cease,
Till every soul in the fire is tried,
And we all have paid the price of Peace.

But a bit of rest and a bit of ease,
Our zeal and courage to retrieve;
Then up and at 'em once again—
We are not dismissed; we're just on leave.

DUTY OF NONCOMBATANT AMERICANS.

Increase production, economize in consumption, lend your money to the Government.

Hold your Liberty bonds and prepare to buy more.

Spread the propaganda of THRIFT—make THRIFT a strong fundamental principle in your life.

MEDICAL MOBILIZATION AND THE WAR

CALL TO RETIRED PHYSICIANS AND NURSES TO RETURN TO PRACTICE.

BY J. M. DODD, M. D.,

Secretary State Board of Medical Examiners.

Conservation is the keynote of every social and economical problem of this war-time period, and to be of service in some useful and helpful capacity is the desire of every true American.

Heavy demands are being made on the medical profession for its doctors and nurses, so that a readjustment to meet the needs of the army and navy and the civilian population is in progress, and we shall be obliged to call into service all of our resources, both active and latent.

The elevation of the standards of medical education has reduced the number of medical colleges and, consequently, the output of these schools, so that there is a shortage of doctors of medicine and there is no probability of our being able to turn out a sufficient number within the next few years to balance the natural losses.

It is evident that we must use every available, competent medical practitioner and those who have retired from active practice or who have moved to territory in which they are not qualified to practice must be brought back into service, at least until the war is over.

The same is true of the nurses. Though the schools for nurses have increased while medical colleges have diminished, there is also a shortage of nurses which is demanding attention and that branch of the profession of healing is busy trying to find a way out of the difficulties. It will help greatly if the nurses who have married or retired from the profession will come back in and be registered and offer their services in whatever line of work their circumstances will permit. The amendment of the law, extending the waiver to June 1, 1918, for the benefit of these older nurses has brought out a large number of applications for registration.

An obligation rests upon us to search out all these unemployed physicians and nurses and urge upon them the importance of making this contribution to the service of the country in its time of need.

Hospitals must be brought to the highest possible state of efficiency and their capacity increased to the fullest limit, for they must aid the medical profession by making it possible for the doctors and nurses to take care of many more patients than they could by visiting them at their homes.

Then there are the sanatoria for the treatment of patients and their education in right living. The hospitals and sanatoria will be called upon to serve as schools for those who, by reason of disease or injury, must change their vocation and manner of living and must be educated and trained, not only in the science and art of self-preservation, but in a useful occupation as well.

There will be an increased number of these defectives as the war goes on and they deserve the very best we can give them, not only in care and support but in making them independent, self-supporting and useful citizens. Doctors and nurses will have an important part in this work and it must be done to a great extent in the hospitals and sanatoria. Therefore, we are providing both for need of the future and one that is already here, if we increase by every legitimate means the number of our doctors, our nurses, and our institutional facilities.

OUR FOREIGN GUESTS.

After a tour of many American cities, which enabled them to meet and address representative groups of American physicians and surgeons, Sir James Mackenzie, noted heart specialist of Edinburgh and London; Colonel Sir William Arbuthnot Lane, veteran surgeon of the Zulu, Egyptian and Boer wars, and authority on bone surgery, and Colonel Herbert Alexander Bruce, of Toronto, now consulting surgeon of the British armies in France, comprising the medical mission sent by the British Government to this country have returned to Great Britain.

"In the travels of our mission through America, we have been to many centers of war activity here," said Colonel Bruce, "and we will have a great deal to say when we get home about the marvelous and effective program which you are carrying out on so colossal a scale. I want to say that it has heartened us very much, and that we know it will hearten the people at home when we report there."

The visitors first came to Washington to pay their respects to Surgeon General Gorgas. Thence they departed for Cincinnati to attend the annual meeting of the Amercian Surgical Association. At a special patriotic session in the Hughes High School, Cincinnati, June 6, under the auspices of the Ohio State Committee, Medical Section, Council of National Defense, Colonel Bruce described the British system of caring for the wounded. He stated that the British have forty hospital trains in France fully equipped with doctors and nurses, each train having a capacity of 600 beds—the whole constituting a mobile hospital to 24,000 bed capacity. He paid tribute to the heroism of the field hospital service and to the American surgeons and physicians in that service.

Sir Arbuthnot Lane told of the treatment of thousands of soldiers wounded in the face, some with jaws gone, others with cheeks or noses shot away. Colonel Lane is consulting surgeon at the Queens' Hospital at Sidcup, where this facial reconstruction or plastic surgery is the special work. "The man who loses an arm. a leg, or is injured in the body, can go back to the bosom of his family, but the man whose face is distorted, no matter how much his family may love and cherish him, suffers most," said Sir Arbuthnot. "So I began to isolate these cases, beginning with five doctors. This start has developed into a magnificent hospital with 750 men, and we are literally making new faces. We have enlisted the services of the best dentists, sculptors, wax workers, and surgeons, and developed specialists in transferring bones from other parts of the body to the face. If you could see how happy these men are, it would be a lasting satisfaction to know their gratitude."

Sir James Mackenzie told of some of the heart cases referred to him. "Instances of 'irritable heart'," he said, "are due to general weakening of the body through illness in the trenches." Outdoor exercise and sports are curative agencies, he said.

Sir James, in speaking of the examination of recruits, said "the tests of a man's fitness as a soldier should depend upon what he has been doing and what he is able to do. A young fellow was sent to me because his heart was supposed to be bad. I asked him what he had been before he entered the service. He said he had been a butcher. I asked him if he had been able to carry the carcass of a sheep upstairs and whether such work had been a regular part of his duties. He said that he had been accustomed to doing exactly that, and frequently, and without physical discomfort; I said: 'I do not need to examine your heart. If you can do work like that you are certainly fit.' Too many men are rejected because of alleged defects which are more apparent than real."

Colonel Bruce speaking of American physicians in France said: "These men went over as medical men and staid as soldiers for they operate at the front lines amid bursting shells and are continually under fire. While I was in France before leaving to come here on this mission, Sir Arthur Sloggett of the British Medical Service sent for me and said he wished me to take a message to America. This is what he said: 'I appreciate the very excellent work which American doctors and American nurses are doing in the British service.' He said they had been a very great help and an inspiration to the service. In fact, they will never forget the American doctors and nurses. He recommended a large number of your medical officers at the front for the same honors that he had recommended for those in his own service, but owing to the regulation of your Government they were not able to accept. On a recent trip to the front, I met also a number of your soldiers, who gave one the opinion when one looked in their faces that nothing would stop them, and you know what they did when they first encountered the Hun quite recently. I don't think you need to worry about the enemy getting a few feet of territory. One or the other side can get some ground if they pay a sufficient price for it, and during the offensive of the 21st of March, and subsequent dates, the Hun paid a very large price for the territory which he took. Even if we should be driven to the sea, and if we have to take to the boats and go to England, this battle is not over 'We will make it so that ships sailing through the Irish sea sail a sea boiling with submarines,' said one of the German leaders in February, 1917. To which England replied: 'Make it boil like the caldrons of hell, and we will sail just the same.' We of Canada and you of the United States are of the same race and blood. Now that we are comrades in arms, we have a still further bond uniting us. I have difficulty in appreciating the difference between Canada and America. I can tell you the difference between England and America. England says: 'As it was in the beginning, is now, and ever shall be. Amen.' America says: 'As it was in the beginning, is now, and by gosh there's got to be a change.' That spirit now represents the opinion of England as well as that of our allied nations.

"The German chancellor when America entered this war very sneeringly remarked that the weight you would throw into the scale would not be greater than that of a straw. To this Mr. Punch replied that he quite agreed with the statement of the German chancellor, but he would like to point out and make the pre-

diction that it would be the last straw which would break the camel's back."

Colonel Lane told of the enormous help given by American surgeons who came over long before America's entry into the war, saying that he had been asked to speak about the difficulty of getting medical men for the miltary service. He said. "The difficulty with us has been to keep them out. I do not suppose you are any different from our men. I have always understood that the medical people in America were the keenest people in the world. Our people have gone without a word. They gave up their practiecs, their futures, their wives and their children. They did not ask: 'How much are we going to be paid?' or 'What is going to become of our families?' they came at once to the aid of their country. I do not think you will have to ask the medical men to come. I think the difficulty, my friends, will be keeping them away."

"When I left England I felt certain that we should win the war sometime," said Colonel Lane. "Since I have been in this country I have become more certain, and I have come to believe that we shall win it soon." Colonel Lane spoke with enthusiasm of the shipbuilding activities he had seen on this side. He regarded as equally efficient the medical organization work in Washington under Surgeon General Gorgas and Dr. Franklin Martin. "You can make a soldier in four months for the sea, earth, or air," he said, "but it takes seven years to make a doctor, and after we get him he must learn his job. It makes a vast difference in the work of a hospital whether or not it is organized for efficiency, and this depends largely upon the fitness of the physicians for their particular work."

Colonel Bruce said that the work of the medical men in the armies had stamped out typhus and typhoid fever, there being when he left France only twenty-seven cases of typhoid fever in an army of two million men. He told of an experience he had had in a hospital bombed by the Germans, adding that sixteen wounded German prisoners had been killed by one of the bombs dropped.

Sir James Mackenzie asserted that England is not in danger of starvation. "Nor are there any signs of famine at present," he said. "Up to the last harvest, food was scarce, and we had a hard time to get the staples of life, especially cheese and potatoes. Now things are running smoothly." Sir James urged that efforts be made to counteract German propaganda in Russia.

Colonel Bruce asserted that the imaginary boundary line between Canada and the United States had been wiped out, and that the present war has cemented the relations between the countries. Speaking of England's independence of Germany, he said: "We make our own dyes, and we do not bother or even give a thought about the supply of German potash. Five thousand ships enter and leave British ports each week. We have loaned 600 ships to France and 400 to Italy. Before the war less than 200,000 women were engaged in work; now the number exceeds one million, in more than 400 branches of munition manufacture. Social distinctions have been leveled in the utter democracy of overalls and caps."

REDUCING SHELL SHOCK.

Frequent cheerful letters from home help to make American soldiers less subject to shell shock, according to W. Frank Persons, Director General of the Department of Civilian Relief, American Red Cross, who has been spending four weeks with the American Expeditionary Forces in France.

"Any worry about the condition of his dependents or relatives tends to put a soldier into a condition where he is subject to shell shock," said Mr. Persons. "I have this on the authority of eminent specialists who are dealing with such cases in the military hospitals. A soldier who is untouched by bullet or shell may, from shell shock, return to his trench in such nervous condition as to require hospital treatment and a long rest. The best insurance against this serious by-product of modern warfare, the physicians say, is for the man to go over the top or meet a charge in a buoyant, untroubled frame of mind in which his sole concern is the serious business at hand. Cheerful letters from home help to produce the proper mental attitude but confidence that the home folks lack for nothing is an essential foundation.

"That our men may be protected as far as possible from worry about their families, and that nothing else that will maintain morale be left undone, it is obvious that the American people must see to it that no family of a soldier lacks for anything that will enable it to write honestly cheerful letters abroad.

"To the American Red Cross has been given leadership in this vital undertaking. With utmost sympathy its 40,000 workers, organized as the Home Service Sections of 5,000 Red Cross chapters, have come already into friendly touch with 300,000 families of soldiers. Whatever the need, this need has been met at once either directly by the Home Service Section, or in co-operation with local agencies."

TUBERCULOSIS IN FRANCE.

France is finding in tuberculosis one of the worst of war's by-products. Before the conflict had continued two years her hospitals were filled with soldiers suffering from the plague and facilities of adequate care of them were lacking. The following facts as to measures invoked are extracted from a recent report by Dr. William Charles White, Chief of the Bureau of Tuberculosis, of the American Red Cross in France:

When the American Red Cross, in co-operation with the Rockefeller foundation, entered the fight against tuberculosis in France, the Service de Sante of the Army was utilizing all the main French institutions, and there was little room available for the women, children and old men suffering from the disease. Last October there were 8,879 Tuberculosis French soldiers, not yet discharged from service, and for these 6,521 beds had been provided in thirty-seven hospitals. Between August, 1914, and November, 1917, there were 80,551 soldiers discharged from the army on account of Tuberculosis and the French department of the Interior undertook to pro-

vide for their care by means of Stations Sanitaires and departmental committees.

Until recently practically no provision had been made for the repatriates—that portion of the population which had been engulfed by the German advance into France and Belgium, and, being no longer of any economic use to Germany, the aged, the young, and the diseased had been sent back into France. A large proportion of these are consumptive. The wretched housing conditions in which many refugees were compelled to live in Paris and elsewhere made them peculiarly subject to Tuberculosis.

A careful survey of the field indicated that the Red Cross could render most effective assistance among these groups. The first opportunity for usefulness came in the survey of conditions in the Tuberculosis barracks which had been provided by the Assistance Publique in connection with the large hospitals and alms-houses in Paris. There were 1052 beds in them, yet only 174 were occupied. Unattractive conditions seemed to explain, in large part, the failure of the sick to make full use of this institution. The American Red Cross thereupon increased the nursing force, established diet kitchens and recreation rooms, and provided additional clothing and materials, such as bed covers and flowers. The institution quickly became more popular and soon was caring for 657 patients. Later, new cure halls, dining rooms, and recreation rooms, were constructed by the Red Cross.

A survey of the institutions outside of Paris showed that these provided 11,000 beds for a population of 39,500,000 persons, with a total death rate from Tuberculosis in 1913 of 84,443. Many of these institutions required additional bedding, food, and equipment, which the American Red Cross undertook to furnish at a cost to it of approximately 100,000 francs a month.

Another plan similar to the Home Hospital plan in New York City now is being used in France, especially for those refugee and repatriates, families with Tuberculosis members. These, if allowed to go into ordinary houses well might spread infection. The new plan contemplates placing such families in small houses especially constructed for the care of a tuberculosis member Each house is composed of three rooms—two sleeping rooms and a living room—with a small porch for the patient. The children will be placed in open-air schools, and those able to work will be given vocational training in such trades as gardening, carpentry, tailoring and shoemaking. The domiciliary care of the consumptive, it is believed, is one of the most important factors in the war against Tuberculosis in France, as elsewhere.

After studying the question of the relation of tuberculosis to the various armies, it was decided that the American army, no matter how careful the exclusion of tuberculosis cases in the draft, would still have to deal with a group of cases which would develop tuberculosis from existing lesions not possible of diagnosis in earlier examinations. It was thought that this was a field of work in which the American Red Cross could give assistance to our own army in France. It seemed obvious that there would appear certain pneumonic types of tuberculosis, certain acute military cases, severe hemorrhagic and pleuritic cases, and probably a number of cases of tuberculosis in parts of the body other than the lungs.

An offer to the Army Headquarters to provide a hospital near the shipping ports where the Red Cross would be given permission to take care of such cases needing attention prior to their return home, has been accepted. The American Red Cross will undertake the provision of one such hospital which then will be turned over to the army. A similar institution may be provided at a second point.

Four tuberculosis hospitals in France are now maintained and conducted solely by the American Red Cross and ninety-six French hospitals are aided with funds and supplies and in addition much educational and visitational work is being done.

DENTAL WORK FOR REGISTRANTS.

One-half million operations free is the achievement of the Preparedness League of American Dentists, an organization comprising more than 15,000 dentists in the United States. They have pledged themselves to give at least one hour of their time daily, including materials, to men selected for the Army, Navy and Marine Corps. The half million mark was reached early this month.

According to the present law, only one dentist is allotted to every 1,000 men in the army. The League is supplementing this work of making recruits dentally fit, by making not only fillings and extractions, but by supplying thousands of crowns and bridges free of charge. In this way, many thousands of men, who had less than the minimum dental requirements to fit them for General Military Service, are able to be inducted into the service.

It has been estimated that if the mouths of American soldiers be kept clean from diseased teeth, 20% of the men in hospitals because of dental infections, will be available for service in the trenches, and the 20% of extra beds will be available for men wounded in war. Thus, according to the League, not only will the efficiency of the army be increased, but its morale, whereas the government will save the hospital expense which these men would incur.

Statistics from hospitals at the front, announces the League, show that 20% of the men in the sick wards are there because of diseases arising from infections from diseased teeth.

Most of the energies of the League will be devoted to men qualified for military service.

"These are the men," explained Dr. Ash, "who will do the actual fighting and who must live in the trenches, and who consequently are more subject to sickness and infection. The most important thing to do for these men is to rid their mouths of bad roots and infected teeth, or any tooth having a history of periodical abscess. The lack of the minimum number of teeth does not excuse any man from military service, but only from General Military Service! The man may be accepted for 'Limited Military Service' even if he has no teeth.

"In all the states, dentists have been appointed members of the Medical Boards, thus enabling co-operation

of physicians and dentists. On every local board in the United States, dentists who have volunteered their services have been appointed. It is the duty of these men to examine the mouths and teeth of the Registrants and send those certified for General Military Service to members of the Preparedness League who are prepared to give them free dental service.

"It is inevitable some men will have been sent to camp as certified for class 1-A, who should have been certified for Special or Limited Military Service. When such a man is re-examined and sent back from camp, it means expense to the Government and embarrassment to the Local Board. The principal thing the Government is anxious to guard against is injustice to the registrant. Thus if the recruit's teeth are examined thoroughly by the detal representative on the Local Board, the possibility of passing men who have less than the minimum dental requirements will be appreciably reduced."

WAR SAFER THAN PEACE.

Great as the danger and large as the losses in the aggregate, the individual soldier has plenty of chances of coming out of the war unscatched, or at least not badly injured.

Based on the mortality statistics of the allied armies, the Bureau of Information at Washington has figured out that a soldier's chances are as follows:

Twenty-nine chances of coming home to one chance of being killed.

Forty-nine chances of recovering from wounds to one chance of dying from them.

One chance in 500 of losing a limb.

Will live five years longer because of physical training, is freer from disease in the army than in civil life, and has better medical care at the front than at home.

In other wars from 10 to 15 men died from disease to 1 from bullets; in this war 1 man dies from disease to every ten from bullets.

For those of our fighting men who do not escape scatheless, the government under the soldier and sailor insurance law gives protection to the wounded and their dependents and to the families and dependents of those who make the supreme sacrifice for their country.

WAR NOTES

Major Edward J. Barrett, of Sheboygan has been placed in charge of the World's largest Military Hospital on Staten Island, New York, where the injured brought back from overseas will be cared for. The hospital will care for more than three thousand at one time, and is constructed with a view for meeting every emergency. This is a distinct honor for one of our Wisconsin men.

Lieutenant E. W. Bowen of Watertown who joined the service some five months ago has been honorably discharged because of physical disability. Dr. Bowen developed symptoms of hyperthyroidism. He will resume his practice at his former location.

The village of Monches and surrounding counties gave a large farewell party in honor of Dr. Connelly, who left for service July 1.

Ripon has contributed three physicians and three dentists to the Medical Reserve Corps.

Dr. E. S. Knox formerly of Bowler who went with the Expeditionary forces was honored by being received at Windsor Castle by King George of England. The doctor was given a letter by King George to deliver to the company of soldiers of which he is a part.

Captain Clarence A. Baer, Milwaukee, who is a member of the American Red Cross, "other there" has been decorated with the Reconnaisance Francaise, a much coveted medal, for his heroic work on the French Front.

On Wednesday night, July 10, friends of Dr. A. S. White, Rice Lake, gave a banquet at his home, to do honor to the Doctor before he left for duty at Fort Oglethorpe.

Dr. Cecil C. Lawhorn of Milwaukee has left on leave of absence from the Muirdale Sanatorium, Wauwatosa, Wisconsin, to return to Franee, expecting to do infants welfare work under De. Lucas for the American Red Cross. He expects to see every fit physician and surgeon "over there" to do our full duty in winning the war completely for America and our Allies.

Physicians under the draft age and listed under the draft for special and limited service are to be inducted August 11th, and sent to Columbus Barracks; according to a telegram received by Governor Phillips from the Provost Marshall General

Capt. T. F. Shinnick, Beloit, has sailed with base hospital No. 50.

Dr. G. H. Conklin, Superior, has arrived in England, according to word received by Superior friends. Dr. Conklin received his training at Fort Riley.

Measures were taken by the army medical corps to prevent the spread of social diseases among the men of the American expeditionary force have reduced the rate almost a half, according to announcement by the war department. The lowest record for the army was in 1916, when the rate was 91.23 per thousand.

The latest report from France shows the present rate to be 47.8 per thousand. This indicates approximately one man in every thousand contracts a social disease each week. Among troops in the United States the rate has been reduced to approximately 21 per thousand yearly.

Through the efforts of the army, it is hoped that great progress can be made during the war in driving out social diseases from this country. From information supplied by the thousands of men in camps, who have

been exposed to the evil, the government authorities are enabled to locate the carriers who are segregated and cured by the civil authorities.

Official commendation of the work of Lieut. G. L. Bellis, Medical Reserve Corps, United States army, in France, affords Milwaukee county special reason for pride and gratification, in the opinion of tuberculosis experts, inasmuch as Lieut. Bellis is in France on leave of absence from Muirdale. He will return when his work in France is completed. Milwaukee county is loaning Dr. Bellis to France.

In a communication from Dr. White, chief of the Bureau of tuberculosis of the American Red Cross, to Homer Folks, director of the department of civil affairs, the ability and efficiency of Lieut. Bellis in positions of large responsibility are spoken of in terms of highest praise. Lieut. Bellis is now in command of the bureau for the district of Lyons. He had personal charge of the construction of the Lyons hospital for tuberculous repatriés and is now organizing a central office for the bureau in Lyons, the second largest city in France.

COMMISSIONS AWARDED.

W. C. Darling, 877 Marquette Ave., Milwaukee.
W. S. Darling, 866 Hackett Ave., Milwaukee.
J. A. E. Eyster, Madison.
Neil Andrews, Oshkosh.
J. F. Fermanwein, St. Mary's Hill, Milwaukee.
J. E. Twohig, Fond du Lac.
J. B. Vedder, Marshfield.
J. F. Wenglesky, St. Mary's Hill, Milwaukee.
R. L. Cowles, Green Bay.
L. G. Sykes, Milwaukee.
Wm. Ackerman, Milwaukee.
P. M. Ross, Milwaukee.
S. S. Salinko, Milwaukee.
L. M. Warfield, Milwaukee.
H. L. Garner, Rhinelander.
A. W. Gray, Milwaukee.
F. M. Harris, Fond du Lac.
J. W. Powers, Burlington.
W. J. Durner, Milwaukee.

ORDERED INTO SERVICE.

Robert J. Bach, Milwaukee, to Fort Riley.
R. L. Cowles, Green Bay, to Fort Riley.
J. J. Minahan, St. Nazianz, to Fort Riley.
A. S. White, Rice Lake, to Fort Oglethorpe.
H. C. Darling, Milwaukee, to Washington, D. C.
Otis Maerchlein, Milwaukee, to Fort Oglethorpe.
A. J. Pullen, North Fond du Lac, to Fort D. A. Russell.
G. T. Mortell, Green Bay, to Fort Riley.
A. Gerend, Cato, to Fort Riley.
H. L. Garner, Rhinelander, to Fort Oglethorpe.

RECENT ORDERS ISSUED TO WISCONSIN PHYSICIANS IN SERVICE.

To Camp Dix, Wrightstown, N. J., for duty, Lieut. Justus Sutherland, Brodhead.

To Camp Grant, Rockford, Ill., for duty, from Camp Logan, Capt. Albert G. Jenner, Milwaukee.

To Camp Jackson, Columbia, S. C., for duty, Lieut. Henry H. Ainsworth, Madison; from Camp Dodge, Lieut. Thomas C. Clarke, Oconto.

To Camp Meade, Annapolis Junction, Md., for duty, from Camp Sherman, Lieut. William N. Moore, Appleton.

To Camp Pike, Little Rock, Ark., for duty, from Fort Riley, Capt. George W. Fifield, Janesville.

To Fort Oglethorpe for instruction, Lieuts. Leo. A. Hoffman, Campsbellport; Ralph B. Quinn, Darlington; Laurel E. Youman, Mukwonago; Charles C. Davin, New Richmond; De Wayne Townsend, Oconomowoc; from Fort Myer, Lieut. Clarence N. Sonnenburg, Sheboygan.

To Lakewood, N. J., for temporary duty, Lieut. Eugene A. Gatterdam, La Crosse.

To report to the commanding general, Philippine Department, for duty, from Camp Cody, Capt. George A. Bading, Milwaukee.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion to Camp Sheridan, Montgomery, Ala., base hospital, Lieut. George M. Smith, Chippewa Falls. On completion to Camp Zachary Taylor, Louisville, Ky., base hospital, Lieut. Anthony H. Looze, Brodhead.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to Camp Sevier, Greenville, S. C., base hospital, Capt. Thomas F. Shinnick, Beloit.

To Camp Custer, Battle Creek, Mich., base hospital, Capt. Harlow S. Roby, Milwaukee.

To Camp Devens, Ayer, Mass., for duty, from Fort Oglethorpe, Lieut. Cornelius N. Stuesser, Oconomowoc.

To Camp Dodge, Des Moines, Ia., for duty, from Fort Riley, Lieut. Harold Kalling, Black River Falls.

To Camp MacArthur, Waco, Texas, base hospital, from Fort Riley, Lieut. Floyd W. Aplin, Waukesha.

To Camp Meade, Admiral, Md., for duty, from Fort Riley, Lieut. Peter L. Scanlan, Prairie du Chien.

To Fort Oglethorpe for instruction, Capt. Allan S. White, Rice Lake; Lieuts. Jens Anderson, Racine; Edward L. Garner, Rhinelander.

To Fort Porter, N. Y., for duty, from Ann Arbor, Capt. John M. Conley, Oshkosh.

To Fort Thomas, Ky., with the Board examining the troops for cardiovascular diseases, from Fort Riley, Lieut. Carlton M. Beebe, Sparta.

To New Haven, Conn., for duty, Lieut. Arthur A. Pleyte, Delafield.

To New York City, Bellevue Hospital, for instruction, and on completion to Camp Upton, L. I., N. Y., base hospital, Lieut. Arthur T. Johnson, Sauk City.

To report by wire to the commanding general, Central Department, for assignment to duty, Capt. Fred D. Jackey, Thorp.

To Whipple Barracks, Ariz., for duty, from Fort Riley, Lieut. Raymond N. Nelson, Horicon.

The following orders have been revoked: To Camp Devens, Ayer, Mass., as assistant to camp surgeon, from Hoboken, Major Edward J. Barrett, Sheboygan. To Fort Oglethorpe for instruction, Lieut. Leo A. Hoffmann, Milwaukee.

To Camp A. A. Humphreys, Accotink, Va., with the board examining troops for tuberculosis, from Camp Laurel, Capt. Leon H. Flaneher, Milwaukee.

To Camp Grant, Rockford, Ill., base hospital, Capts. Harry M. Kay, Madison; Philip A. Fox, Milwaukee; Gideon Benson, Richland Center; Lieut. Hugh C. Russell, Milwaukee.

To Camp Lewis, American Lake, Wash., for duty, from Fort Riley, Capt. Arthur E. Winter, Tomah; Lieut. Louis M. Pearson, Tomahawk.

To Camp Zachary Taylor, Louisville, Ky., base hospital, Capt. Christian U. Senn, Ripon. For duty, from Fort Riley, Major William W. Pretts, Platteville.

To Fort Riley for instruction, Lieut. Wayne A. Munn, Janesville.

To New Haven, Conn., for duty, Lieut. Edward P. Allen, Waukesha.

Honorably discharged on account of physical disability existing prior to entrance into the service, Lieut. Emmett W. Bowen, Watertown.

To Army Medical School for instruction, Lieut. Edgar W. Albers, Milwaukee.

To Camp Custer, Battle Creek, Mich., base hospital, Lieut. Brand Starnes, Mauston.

To Camp Devens, Ayer, Mass., for duty, from Camp Grant, Lieut. Edmund H. Mensing, Milwaukee.

To Camp Dix, Wrightstown, N. J., base hospital, from Camp Crane, Lieut. Charles B. Rydell, Superior.

To Camp Grant, Rockford, Ill., for duty, from Fort Riley, Lieut. John R. Sheean, Milwaukee.

To Camp Sevier, Greenville, S. C., for duty, from Fort Oglethorpe, Lieut. Adam L. Curtin, Milwaukee.

To Camp Travis, Fort Sam Houston, Texas, base hospital, from Fort Oglethorpe, Lieut. Frederick J. Korthals, Milwaukee.

To Fort D. A. Russell, Wyo., for duty, Lieut. Albert J. Pullen, North Fond du Lac.

To Fort Des Moines, Iowa, base hospital, from Camp Zachary Taylor, Lieut. Ernest L. Hennig, Beloit.

To Fort Oglethorpe for instruction, Lieuts. Herman C. Meyer, La Crosse; Otis W. C. Maercklein, George G. Wallschlaeger, Milwaukee.

To Fort Riley for instruction, Lieut. Claude H. Oliver, Boyceville.

To Jefferson Barracks, Mo., for duty, from duty as a contract surgeon, Capt. Louis M. Warfield, Milwaukee.

To New Haven, Conn., for duty, Capt. Frank Brockway, Oshkosh.

To report by wire to the commanding general, Central Department, for assignment to duty, Lieuts. Thomas W. Nuzum, Janesville; William A. Edwards, La Crosse; Francis J. Donnelly, Monches; Edgar J. Knapp, Rice Lake.

ABSTRACTS

Color Blindness Among U. S. Seamen. Report of Public Health Service Gives Valuable Data. The importance of differentiating between those who are dangerously color-blind—that is, unable at all times to distinguish between red and green—and those who are only slightly color-blind, is brought out in a recent study conducted by the U. S. Public Health Service and reported in Public Health Bulletin No. 92.

The following classes are regarded as dangerously color-blind and therefore to be excluded from positions in which they would be required to read colored signal lights: (1) those who are able to see but three or less colors in the spectrum, (the normal person sees six or seven); (2) those who see more than three colors in the spectrum, but who have the red end so shortened as to prevent the recognition of a red light at a distance of two miles; and (3) those with a central scotoma (that is, a blind or partially blind area in the field of vision) for red and green.

It was concluded that this class of persons could be distinguished from those harmlessly color blind by the use of the Eldridge-Green color lantern, which was found preferable to colored yarns. The theories on which the color lantern is based are given in detail in the publication.

Another feature of the investigation was the study of the prevalence of color blindness. Excluding those able to distinguish five colors in the spectrum, it was found that color blindness occurs in about 8.6 per cent of men and 2.2 per cent of women. Color blindness of a degree dangerous in occupations requiring the recognition of colored signal lights was found to occur in about 3.1 of men and 0.7 per cent of women. Among refractive conditions of the eye, color blindness occurs least frequently in eyes apparently without demonstrable refractive error; it occurs most frequently in eyes showing mixed astigmatism.

The examinations were made as a part of other studies of the effect of illumination on vision, conducted as a part of an illumination survey of the Federal department buildings in Washington, D. C. One thousand persons were tested with the Edridge-Green lantern to determine both the value of the lantern and the effect, if any, of refractive conditions, lesions, and anomalies of the eye, and also of sex, upon different degrees of color perception.

A special study of the Jennings self-recording worsted test was also made, 50 persons being tested with this and other tests. The results with the Jennings test were found to be too inaccurate for most work, although it was found to be superior to other tests in certain lines of work where great accuracy and the classification of color defects were not essential.

BOOK REVIEWS

1917 Collected Papers of the Mayo Clinics, Rochester, Minn. Octavo of 866 pages, 331 illustrations. Philadelphia and London. W. B. Saunders Company. 1918. Cloth, $6.50 net.

This work maintains the standard of excellence established in the previous eight volumes from the Mayo Clinic. It covers the following subjects: Alimentary Canal Urogenital Organs, Ductless Glands, Heart, Blood, Skin, Venereal Diseases, Head Trunk and Extremities, and Technic. It is another fine contribution to scientific medicine covering so varying a field as to make a detailed review impossible in this department of the Journal. These series of collected papers should be somewhere available for all progressive workers.

Local and Regional Anesthesia, including Analgesia. Second Edition, Reset. By Carroll W. Allen, M. D., of Tulane University, New Orleans, with an introduction by Rudolph Matas, M. D., of Tulane University, New Orleans. Octavo of 674 pages with 260 illustrations. Philadelphia and London. W. B. Saunders Company. 1918. Cloth, $6.50 net.

This is a most exhaustive work of nearly 700 pages on the subject of local and regional anesthesia with chapters on spinal epidural, para vertebral and para sacral analgesia and on other applications of local and regional anesthesia to the surgery of the eye, ear, nose and throat and to dental practice. The author who has been director of the surgical clinics of the College of Medicine of Tulane University for nearly twenty-five years has given us the most complete work on the subject published to date. This new second edition has been brought up to date and is the last word on the subject. Many small works and monographs have been available but nothing as complete as that presented by Doctor Allen. The chapters on local anesthesia, explaining in detail its use for the different operations will prove of great value to every practitioner doing any surgery at all. It is well bound and printed on a good grade of paper and beautifully illustrated. It is a book fitted for the library of every physician, specialist or general practitioner.

Diagnosis and Treatment of Venereal Diseases in General Practice. By L. W. Harrison, Lt. Colonel, R. A. M. C., Lecturer on Venereal Diseases and officer in charge of the hospital Rochester Row. 482 pages, illustrated. Several in colors, Oxford University Press, New York City, 1918. Cloth, price $7.50.

Venereal diseases have a double claim on our attention. They provide a field for scientific research and they levy a toll on our national resources which cannot be ignored at this time when it is necessary to keep our troops at the highest point of efficiency. This work is of special interest. It should be in the hands of all engaged in the great national campaign to clean up this curse. The work is most complete and covers thoroughly these diseases—the equipment required for their diagnosis and treatment and laboratory diagnosis. It is beautifully illustrated with sixteen colored plates and 84 half-tones. It is an exhaustive, authorative work on the subject.

Diseases of the Heart. By Frederick W. Price, M. D., F. R. S., (Edinburgh), 472 pages, illustrated. Oxford University Press, New York City, 1918. Cloth, $7.50 net.

The author has produced from the point of view of a clinician avoiding matter of merely theoretical interest, a concise yet exhaustive work on the diagnosis, prognosis and treatment of diseases of the heart by modern methods. The tremendous advance in the study of heart disease in recent years by means of such agencies as the clinical polygraph and electro-cardiograph make it possible to now analyze the cardiac action in a manner never before possible. All abnormal cardiac conditions are treated in detail as are all modern methods of diagnosis. With the special interest now being shown in diseases of the heart by reason of examination of drafted men, this book will be of special value to all engaged in this work. We are glad to recommend it.

The Prevention of Venereal Disease. By Otto May, M. A., M. D., Late Secretary of the English National Council for combating venereal diseases. 240 pages, not illustrated. Oxford University Press, New York City, 1918. Cloth, $3.00.

This work covers the subject from a rather military point of view. It covers education and instruction treatment in relation to prevention, artificial prophylaxis, etc., and in an appendix gives a lecture to troops and legislation which has been past on the subject. A long list of English institutions available for diagnosis and treatment is published in the appendix. The book will be of more interest to miltary men than to the general practitioner of America.

Applied Bacteriology. By C. H. Browning. M. D., D. P. H., director of the Baland-Sutton Institute of Pathology, The Middlesex Hospital. 291 pages, a few illustrations. Oxford University Press, New York City, 1918. Cloth, $2.50 net.

These collected studies will appeal to both laboratory workers and those concerned with the clinical side of medicine. The first fifty pages are given to the diagnosis of "enterica" infections, studies on antisepties, the isolation of typhoid and para-typhoid bacilli. Antibodies and tetanus are especially well covered. It is a book which will be of interest to laboratory workers.

Materia Medica and Therapeutics for Nurses. By John Foote, M. D., Assistant Professor of Materia Medica, Georgetown University. Third edition, revised and enlarged, 310 pages. J. P. Lippencott Company, Philadelphia, 1918. Cloth, $1.75.

This is a new and completely revised edition conforming to the standards of the United States pharmacopoeia. 9th revision. The Latin official names of drugs and preparations have been added in this revision, and in the reference table the official name of each drug or preparation recognized in the European pharmacopoeia included this last as a result of an anticipated foreign demand. The work will simplify the study of materia media and therapeutics for nurses as it limits the number of important remedies to the student and appends a reference list to cover the other frequently used drugs and preparations. We note with pleasure that special attention is given to the Untoward action of drugs so the nurse may note and record these actions when they occur.

Amputation Stumps. By G. Martin Huggins, F. R. C. S., 228 pages. Illustrated. Oxford University Press, New York City, 1918. Cloth, $2.75.

The author who has been surgical specialist at the Pavilion general hospital at Brighton was responsible for the treatment of three thousand amputation cases during the past year. The work is intended for those surgeons engaged in the treatment of cases in which amputation has been performed. It would be of special value to those engaged in any orthopoedic work and those who will take part in the great reconstruction work to come. It is beautifully illustrated with ninety-five half-tones and completely yet concisely covers the subject. It is well worth while.

Bipp Treatment of War Wounds. By Rutherford Morison, Professor of Surgery, Durham University. 72 pages. Illustrated. Oxford University Press, 1918. Cloth, $1.00.

This little addition to the Oxford War primers is a most brief and concise statement regarding the Bipp treatment of war wounds. A summary of the technique used, fractures, necrosis and chronic bone cavities. It is a small clinical teaching manual, relying as much on the illustrations as on the subject matter.

There be certain animals that be poisonous in certain of their parts, some in the brain as in bats and cats; some in the tails, as in deer and scorpions; some in the blood, as in old bulls and in toads; and in men who be demoniac; some in the sputum as in toads, and in fasting men, this indeed not evil to man but to scorpions and serpents.

—Petrus d' Apono, De Venena.

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ORGANIZED 1841

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The Wisconsin Medical Journal, Official Publication

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Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
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Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	G. C. Nedry, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	G. B. McKnight, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
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Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
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Winnebago	J. W. Lockhart, Oshkosh	E. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Ruckie, Grand Rapids.

SOCIETY PROCEEDINGS

EAU CLAIRE COUNTY

A meeting of the Eau Claire County Medical Society was held at the Eau Claire Club Wednesday evening, July 10th. Doctor Rock Sleyster, of Waupun, secretary of the State Medical Society, was present and addressed the members on war conditions effecting the medical profession.

R. E. MITCHELL, *Secretary.*

FOND DU LAC COUNTY

The Fond du Lac County Medical Society gave a farewell banquet at the Palmer House on June 6th in honor of Captain S. E. Gavin, who left the 13th for Camp Colt, Gettysburg, to begin active duty in the army medical corps.

Plates were laid for twenty-five and in view of the patriotic nature of the occasion American flags formed the principal decorations at the tables. The banquet was served at 7 o'clock and was followed by an informal program of toasts.

The speaker of the evening was Dr. Rock Sleyster of Waupun, secretary of the state medical society, who discussed the medical aspect of the war situation and also paid tribute to the guest of honor. Dr. Henry Twohig also gave a felicitous talk and Capt. Gavin responded in grateful vein to his conferers for the courtesy of the evening and the sentiments expressed.

On July 2d a farewell banquet was given Doctor A. J. Pullen of North Fond du Lac, who left for service in the west.

F. M. MCCAULEY, *Secretary.*

MILWAUKEE COUNTY.

A special meeting of the Milwaukee County Medical Society and a smoker was held at the Hotel Wisconsin Monday evening, July 8th. Doctors L. F. Jermain, H. M. Brown, H. V. Ogden and Father Moulinier spoke on the coming campaign for the Marquette medical school. The Society, without dissenting vote indorsed the campaign.

ORGANIZATION NEWS

MADISON MEETING OF DISTRICT SOCIETY.

The Tri-State District Medical Society extends to the physicians of Wisconsin, Iowa, and Illinois a hearty invitation to attend its annual scientific and clinical meeting to be held at Madison, Wisconsin, August 20, 21 and 22.

Madison is a beautiful city surrounded by Wisconsin lakes, an ideal location for a medical meeting at this time of the year. Besides the benefits the members and other physicians will derive from the meeting, it will furnished a splendid outing for the guests of the association.

Our experience has been that the latter part of August and the first part of September is an ideal time for a meeting in this part of the country. The weather is generally cool, and the roads permit the physicians to come from all parts of the three states in their automobiles.

The indications are now that the meeting will be a very notable one. Besides the time devoted to the clinics and the addresses by notable men of the profession, the medical phase of the war will receive considerable attention.

One of the sessions of the meeting will be devoted to the selective service regulations. At this meeting there will be a joint conference of the local, district, and medical advisory boards of the three states. Provost Marshall General Crowder of the war department has kindly designated Major Hubert Work and Colonel Easby-Smith of the Provost Marshall General's office, Washington, to take charge of this meeting.

The Governors of three states along with their medical aides, Dr. Rock Sleyster of Wisconsin, Dr. W. W. Pearson of Iowa, and Dr. John Dodson of Illinois, have signified their hearty co-operation in arranging this conference.

Another feature of the program will be twenty-four papers and twenty-four discussions by local physicians from the three states.

The social feature will be observed as usual and the Doctors are invited to bring their wives, daughters, and lady friends.

Madison as a medical center is one of the finest in the Middle West. The physicians and hospitals of this city are among the best in the country, and the very fact that the meeting is to be held in this city is synonymous with success. Madison and its physicians extend you a hearty invitation to be a guest at this meeting.

Program Committee—

Dr. W. T. Lindsay, Madison, Wis.
Dr. H. G. Langworthy, Dubuque, Iowa.
Dr. C. L. Best, Freeport, Ill.

WILLIAM B. PECK, *President,*
NELSON C. PHILLIPS, *Secretary.*

ANNOUNCEMENT.

The Tri-State District Medical Society extends to the physicians of Wisconsin, Iowa, and Illinois a hearty invitation to be present at its annual scientific, clinical and social meeting to be held in the State Capitol building (assembly chamber), Madison, Wisconsin, August 19, 20, 21 and 22.

A large portion of the time of this year's meeting will be taken up with subjects pertaining to the medical phase of the war.

Surgeon General William C. Gorgas of the United States Army has conferred a great favor upon the society by agreeing to be present, if possible. The society is also very fortunate in having upon its pro-

gram Major Hubert Work and Colonel Easby-Smith along with the medical aides, Drs. Rock Sleyster, of Waupun, John M. Dodson of Chicago, and W. W. Pearson of Des Moines, who will have charge of a conference of exemption boards to be held on the second day of the meeting. We feel deeply grateful to Provost Marshall General Enoch H. Crowder for designating Major Work and Colonel Easby-Smith to represent the Provost Marshall General's office.

The military feature of the program is also being greatly aided by the hearty co-operation of the medical corps of the military camps of Iowa, Wisconsin, and Illinois. Each of the corps has designated members of its staff to take part on the program. An invitation has been extended to all the medical officers, and the indications are now that all those who can be spared will be present.

Another very interesting part of the program will be the diagnostic clinics which will be held every morning of the meeting, and will cover the different fields of medicine and surgery. They will be conducted by the notable men of the profession who will be the guests of the association. The Madison physicians are arranging for an abundance of material for these clinics. Physicians from other cities and towns who have interesting or obscure cases for diagnosis are urged to bring them to the clinics. Information can be obtained in regard to the matter by writing Dr. T. W. Tormey, Chairman of the Surgical Committee, and Dr. H. P. Greeley, Chairman of Medical Committee.

Madison as a medical center is one of the finest in the Middle West. The physicians and hospitals of this city are among the best in the country, and the very fact that the meeting is to be held in this city is synonymous with success. Madison and its physicians extend to you a hearty invitation to be a guest at this meeting.

PROGRAM OF TRI-STATE DISTRICT MEDICAL SOCIETY.

FIRST DAY, AUGUST 19th, 1918.

10:00 to 12:00 a. m. Registration in Lobby of Assembly Chamber, State Capitol.

12:30 to 2:00 p. m. Luncheon in Capital Cafe—under the Dome.

2:00 to 5:00 p. m. Visits through State House, University and other points of interest. Golf at Maple Bluff Golf Club. Golfers bring your instruments.

9:30 p. m. Take boats at foot of S. Carroll Street, two blocks below Park Hotel, for Esther Beach. Dancing in Open Air Pavilion.

SECOND DAY, AUGUST 20th, 1918.

7:00 a. m. Diagnostic Clinic (Surgical).
Major Joseph Colt Bloodgood, Baltimore, Md.

9:00 a. m. Address of Welcome.
Mayor J. C. Sayle.

9:30 a. m. Response to Address of Welcome.
Dr. J. H. Guthrie, Honorary President Tri-State District Medical Society, Dubuque, Ia.

9:50 a. m. Diagnosis of Cardiac Conditions from the Standpoint of Military Service.
Dr. J. S. Evans, Madison, Wisconsin.

10:00 a. m. Syphilis of the Thyroid Gland with a Review of Recent Literature.
Dr. Don Deal, Springfield Illinois.

10:30 a. m. The Thyroid Gland, Its Functions and Diseases.
Dr. W. J. Herrick, Ottumwa, Iowa.
Discussion: Dr. A. M. Miller, Danville, Illinois.

10:50 a. m. A Study of One Thousand Cases Operated Upon for Goiter.
Dr. E. P. Sloan, Bloomington, Illinois.
Discussion: Dr. R. H. Jackson, La Crosse, Wisconsin.

11:10 a. m. Address in Obstetrics.
Dr. Edward Davis, Philadelphia, Pennsylvania.
Subject: Obstetrics.

Afternoon Session.

1:15 p. m. The Feeding of Babies with Reference to Abnormal Bowel Movements.
Dr. John W. Van Dersice, Oak Park, Illinois.

1:35 p. m. Trachoma and its Relation to the General Practitioner.
Dr. Corydon G. Dwight, Madison, Wisconsin.
(Lantern Slides.)
Discussion: Dr. Frederick A. Davis, Madison, Wisconsin.

1:55 p. m. Address in Children's Diseases.
Dr. Charles Kerley, New York City.
Subject: Gastro-intestinal Disorders Dependent upon Mechanical Agencies in Children.
(Lantern Slides.)

2:55 p. m. Our Duty to the Registrants.
Dr. W. L. Allen, Davenport, Iowa.

3:15 p. m. Conference of Local, District and Medical Advisory Boards.
In regard to the Selective Service Regulations.
In charge of Major Hubert Work and Colonel Easby-Smith of Provost Marshall General's Office, Washington, D. C.
Together with Medical Aids, Rock Sleyster of Waupun, John M. Dobson of Chicago, and W. W. Pearson of Des Moines, Iowa.

1:00 p. m. Ladies' Entertainment. Progressive Luncheon.
Ladies will meet at the Rotunda of the Capitol.

7:30 p. m. Orpheum Party.

Evening Session.

7:00 p. m. The Surgery of the Gall Bladder and Ducts.
Dr. James N. Neff, Chicago, Illinois.
Discussion: Dr. Jos. Dean, Madison, Wisconsin.

7:30 p. m. Fractures of the Extremeties.
Dr. P. A. Bendixen, Davenport, Iowa.
Discussion: Dr. C. W. Hopkins, Chicago, Illinois.

7:50 p. m. Address in Surgery.
Dr. Benjamin Davis, Chicago, Illinois.
Subject: Blastomycosis. (Lantern Slides.)

8:35 p. m. The Roentgen Diagnosis of Gastro-Intestinal Lesions of the Upper Right Quadrant, Lantern Slides of Ulcers under Medical Management; Mistakes in Diagnosis.
Dr. J. W. Rountree, Waterloo, Iowa.
Discussion: Dr. Charles R. Bardeen, Madison, Wisconsin.

8:55 p. m. Address in Surgery.
Dr. J. Rawson Pennington, Chicago, Illinois.
Subject: A Consideration of the Carrel-Dakin Method of Treating Wounds and the Paraffin War Treatment of Burns. (Lantern Slides.)

9:40 p. m. Radium as an Aid to the Surgeon.
Dr. C. W. Hanford, Chicago, Illinois.
Discussion: Dr. W. E. Bannen, La Crosse, Wisconsin.

THIRD DAY, AUGUST 21st, 1918.

Morning Session.

7:00 a. m. Diagnostic Surgical Clinic, Major John B. Deaver, Philadelphia.
Pediatric Clinic, Dr. Charles Kerley, New York City.

9:00 a. m. Vomiting Conditions.
Dr. Paul E. Gardner, New Hampton, Iowa.
Discussion: Open.

9:20 a. m. Practical Ideas Regarding the Treatment of Acidosis, Commonly Called Uremia.
Dr. J. H. Stealy, Freeport, Illinois.
Discussion: Open.

9:40 a. m. To Meudota by Boat or Cars.

10:20 a. m. Psychiatry and the War.
Dr. Arthur W. Rogers, Oconomowoc, Wisconsin.
Discussion: Open.

10:40 a. m. Delusions, Illusions, and Hallucinations of Exceptional Character Found in a Series of Psychoses.
Dr. Richard Dewey, Wauwatosa, Wisconsin.
Discussion: Open.

11:00 a. m. Clinic—Mental Diseases.
Address in Mental Disease.
Dr. Charles W. Burr, Philadelphia.
Subject: The Relation of the Ductless Glands to Mental Function.
12:30 p. m. Luncheon at Mendota State Hospital.

Afternoon Session.

1:45 p. m. Abdominal Emergencies.
Dr. D. J. Twohig, Fond du Lac, Wisconsin.
Discussion: Dr. Gilbert Stannard, Sheboygan, Wisconsin.
2:05 p. m. Sarcoma: Reports of Three Cases.
Dr. J. H. Guthrie, Dubuque, Iowa.
Discussion: Dr. W. T. Sarles, Sparta, Wisconsin.
2:25 p. m. Address in Surgery.
Major Joseph Colt Bloodgood, Baltimore, Maryland.
Subject:
3:25 p. m. The Bacteriology of Some of the Acute Infectious Diseases.
Dr. W. D. Stovall, Madison, Wisconsin.
Discussion: Dr. Sheldon Clark.
3:45 p. m. Ureteral Calculi.
Dr. William Jepson, Sioux City, Iowa.
Discussion: Dr. P. L. Markley, Rockford, Illinois.
4:05 p. m. Address in Medicine.
Dr. Howard Fussell, Philadelphia.
Subject: Necessity and Practicability of Laboratory Work in the Practice of the Family Physician.
3:30 to 5:00 p. m. Automobile Tour of the City for Ladies.
Assemble at New Park Hotel.
Tea at Country Club.

Evening Session.

7:00 p. m. Skin Grafting.
Dr. John F. Pember, Janesville, Wisconsin.
Dr. T. W. Nuzum, Janesville, Wisconsin.
Discussion: Dr. Karl W. Doege, Marshfield, Wisconsin.
7:20 p. m. Subject announced later.
Dr. Carl E. Black, Jacksonville, Illinois.
Discussion: Open.
7:40 p. m. Address in Surgery.
Major Fred H. Albee, New York City.
Subject: Reconstructive Military Surgery. (Moving Pictures and Lantern Slides.)
9:00 p. m. Address in Surgery.
Dr. William Lower, Cleveland, Ohio.
10:00 p. m. Smoker at Madison Club, with Entertainment Features.

FOURTH DAY, AUGUST 22nd, 1918.

Morning Session.

7:00 a. m. Diagnostic Surgical Clinic, Dr. Austin Flint, New York City.
Medical, Dr. Howard Fussell, Philadelphia.
9:00 a. m. Thrombosis from Contusion of the Arteries of the Lower Extremeties.
Dr. David Fairchild, Clinton, Iowa.
Discussion: Dr. J. F. Smith, Wausau, Wisconsin.
9:20 a. m. The Regimental Surgeon.
Major R. C. Bourland, Rockford, Illinois.
Discussion: Open.
9:40 a. m. Address upon Medical Questions of the Day.
Dr. Alexander Craig, Chicago, Illinois.
10:20 a. m. Subject: Not Announced.
Major J. C. Dallenbach.
Designated by Camp Robinson, Wisconsin.
10:40 a. m. The Principles Which Must Govern the Plastic, Facial and Oral Restorations for War Injuries.
Dr. Geo. V. I. Brown, Milwaukee, Wisconsin.
Discussion: Dr. D. D. Culver, Aurora, Illinois.
11:00 a. m. Address in Gynecology.
Dr. Austin Flint, New York City.
Subject: A Contract Between the Radical and Conservative Methods of Treatment of Eclamptic Conditions.
Ladies Boat Ride and Luncheon.

Afternoon Session.

1:00 p. m. Military Subject.
Major W. G. Alexander.
Designated by Camp Dodge, Iowa.
1:20 p. m. Duties of the Medical Officer.
Major Harry S. Gradle.
Designated by Camp Grant, Illinois.
1:40 p. m. Address:
Surgeon General William C. Gorgas, Washington, D. C.
2:40 p. m. Address:
Colonel Frank Billings, Chicago, Illinois.
3:40 p. m. Address:
Major John B. Deaver, Philadelphia, Pennsylvania.
4:40 p. m. Address:
Major L. L. McArthur, Chicago, Illinois.
7:00 p. m. Banquet for Doctors and their Ladies, Lathrop Hall.

Evening Session.

6:30 p. m. Banquet for Doctors, Ladies and Invited Guests.
Toastmaster, Judge J. B. Winslow, Chief Justice of the Wisconsin Supreme Court.
Addresses.
Gov. E. L. Philipp, of Wisconsin.
William C. Gorgas, Surgeon General, United States Army.
Guests of the Association.
Dr. Gustave Windesheim, President Wisconsin Medical Society.
Dr. Max T. Witte, President Iowa Medical Society.
Dr. Edward Fiegenbaum, President, Illinois Medical Society.
Signed, William B. Peck, President.
Nelson C. Phillips, Secretary.

Program Committee:
William T. Lindsay, Madison.
Henry G. Langworthy, Dubuque.
Charles L. Best, Freeport.

MADISON COMMITTEE.

General Chairman:
L. H. Prince, President Dane County Medical Society.

Vice-Chairman:
W. H. Sheldon, Secretary Dane County Medical Society.

Registration and Exhibits:
Arthur G. Sullivan, Chairman.
W. T. Lindsay.
Jas. A. Jackson, Jr.
Mary E. Regan, R. N.
Amy B. Chamberlain, R. N.

Reception and Entertainment.
C. G. Dwight, Chairman.
Herman Gilbert.
Frank Drake.
C. R. Bardeen.
S. R. Boyce.
L. R. Head.
F. A. Davis.
C. A. Harper.
H. E. Purcell.
J. C. Sommers.
D. B. Collins.
Richard Aylward.
W. J. Ganser.
G. A. Keland.
J. K. Chorlog.
Don Mowery.

Ladies Entertainment:
Mrs. F. W. Tormey, Chairman.
Mrs. Richard Aylward.
Mrs. S. R. Boyce.
Mrs. Stanley J. Briggs.
Mrs. J. K. Chorlog.
Mrs. Fred S. Davis.
Mrs. Jos. Dean.
Mrs. Jas. Donovan.
Mrs. C. G. Dwight.
Mrs. Jas. Evans.
Mrs. P. R. Fox.
Mrs. W. J. Ganser.
Mrs. Herman Gilbert.
Mrs. H. P. Greeley.
Mrs. C. A. Harper.
Mrs. L. R. Head.
Mrs. J. A. Jackson.
Mrs. R. H. Jackson.
Mrs. G. A. Keland.
Mrs. W. T. Lindsay.
Mrs. F. S. Meade.
Mrs. L. H. Prince.
Mrs. H. E. Purcell.
Mrs. F. S. Rinker.
Mrs. W. H. Sheldon.
Mrs. C. S. Sheldon.

Mrs. J. C. Sommers.
Mrs. W. W. Stebbins.
Mrs. A. G. Sullivan.
Mrs. Robt. Van Valzah.

Finance Committee:
Jos. P. Donovan, Chairman.
Joseph Dean.
F. S. Meade.
S. J. Briggs.
W. W. Stebbins.

Clinics:
Medical:
H. P. Greeley, Chairman.
L. R. Head.
Frank Drake.
C. S. Sheldon.
Herman Gilbert.
J. S. Evans.

Surgical:
T. W. Tormey, Chairman.
R. H. Jackson.
P. R. Fox.
Jos. P. Dean.
A. G. Sullivan.

NEWS ITEMS AND PERSONALS.

Dr. O. H. Foerster has accepted a commission in the Medical Reserve Corps, and Dr. R. G. Washburn has assumed charge of his office and will conduct his practice during the duration of the war.

Dr. William J. Mayo was the principle speaker at the opening dinner in connection with the Marquette Drive.

Mrs. S. P. Jones of Marinette has been elected as visiting nurse of the city of Marinette. She takes the place of Miss Helen Swenson, who is now in France, and will begin her work September 1.

Dr. J. A. Lyons of Bear Creek has sold his property and has located in Eau Claire.

Dr. G. Armstrong, of Chicago, a recent graduate has located in New London.

The baby's fresh air pavilion at the North Shore pumping Station, Milwaukee, was opened July 8 and will be kept open until the middle of September.

Drs. Rosenberry and Zilisch of Wausau recently appeared before the city council on the question of the new laboratory. The council voted to engage a competent person to take charge of the laboratory.

Dr. Taylor of Woodford and Dr. R. W. Spring of Chicago have decided to locate at Brodhead.

A recent news despatch from Washington gave the following:

"The government is about to assume control of the entire medical profession in the United States to obtain sufficient doctors for the fast growing army.

The mobilization is to be accomplished either by enrolling the doctors in a volunteer service corps under pledge to accept whatever service—military or civilian—is assigned to them by the governing body of the corps, or, if the voluntary plan should not be successful, by legislation, providing for drafting them into government service."

Dr. O. H. Foerster was elected chairman of the Section on Dermatology of the American Medical Association at the last annual meeting held at Chicago.

Dr. H. N. Cohen has removed from Wilton to Tomah.

Dr. F. E. Kosanke has removed from Fort Atkinson to Watertown.

Dr. Jeremiah Donovan, of Milwaukee, who has been pursuing a course in Proctology at the New York Polyclinic, will return to Milwaukee August 1st and resume his practice, which will be limited to the Diagnosis and Treatment of Diseases of the Colon, Sigmoid and Rectum.

Physicians and druggists are co-operating splendidly with the children's year campaign committee in the follow-up work which is being planned by the committee. The general outline of the work covers a visit to each of those homes containing children below normal standard in the hope that advice and care can be given the parents to help raise the general health standard of the children.

Dr. Anna M. Reed, Michigan City, Ind., has accepted a position at Muirdale sanatorium, Wauwatosa, as resident physician, and will report July 15. Mrs. Reed's husband, A. B. Reed, is in France doing war work. She is a graduate of the University of Michigan and was associated with Dr. T. B. Saths at Edwards sanatorium in Chicago for three years.

Manufacture of Cellucotton, the synthetic absorbent gauze which is supplanting absorbent cotton in Red Cross and medical work, will commence in the mill of the Kimberly Clark Company at Neenah within a week. The Kimberly mill is at present the only one in the country manufacturing it. Reconstruction of the Neenah mill has been going on for some time with the end of manufacturing the cellucotton in mind.

Problems of community health with many war-time phases, will be featured at the fourth biennial conference of health officers of the state of Wisconsin, to be held in Madison, Aug. 7 and 8 under the auspices of the state board of health. The law requires towns, villages and cities to send their health officers to this conference at the community's expense. There are 1,684 health officers in Wisconsin.

Indorsement of the effort of Marquette medical school to raise the endowment fund for which it will start a drive in the near future has been given by President Wilson.

In his letter the president reiterates the statement frequently made by medical men and well informed laymen that the maintenance of high grade medical schools at their present stage of efficiency is a capital necessity at this time. Mr. Wilson's letter follows:

"Your letter concerning the school of medicine of the Marquette University gives me an opportunity to express, as the medical advisory commission of the council of national defense has repeatedly expressed, a very deep interest in the maintenance of our medical schools. It is of capital importance to the country that they should be

maintained at as high a degree of efficiency as possible. Never before did the nation need so large a number of thoroughly trained physicians and surgeons."

Dr. H. V. Ogden has been selected as general chairman of the campaign to be launched shortly for funds for the Marquette University School of Medicine; Judge A. C. Backus will be vice-chairman; Fred Vogel, Jr., treasurer; Katherine R. Williams, executive secretary. Other members of the committee are Louis Allis, Dr. H. M. Brown, Mrs. Louis Auer, John M. Callahan, Dr. Hoyt E. Dearholt, Ben V. Dela Hunt, Mrs. Otto Falk, Judge John C. Karel, Walter Kasten, John C. Kleczka, Mrs. John W. Mariner, Miss Elizabeth G. Marshall, Henry L. Nunn, Dr. A. J. Patek, Judge M. S. Sheridan, Frank B. Schutz, Nat Stone, Mrs. Henry Sullivan, Theodore Trecker, Mrs. Frank L. Vance, A. T. Van Scoy, E. R. Wagner, Dr. W. C. F. Witte, Mortimer I. Stevens, Rev. C. B. Moulinier, L. W. Nieman.

The trustees of the medical school who will administer this endowment fund are the Rev. Herbert C. Noonan, chairman; Judge A. C. Backus, A. A. Schlesinger, Fred Vogel, Jr., John Barnes, W. W. Coleman, Rev. James D. Foley, Dr. L. F. Jermain, Rev. C. B. Moulinier, Dr. H. V. Ogden, Rev. Eugene Rudge, Theodore Trecker, Harry S. Johnson, Henry L. Nunn, Dr. H. S. Pritchett, president of the Carnegie Foundation for the Advancement of teaching.

DEATHS

Dr. A. J. Provost, of Oshkosh, died at Hot Springs, Ark., Sunday July 7th. Dr. Provost received a commission as Captain in the Medical Corps of the army and was in charge of the eye, ear, nose and throat cases at Fort Riley, and later at Fort Bliss. He was born in Dodge County January 14th, 1863. He was for several years employed as railroad conductor on the Soo line. He had practiced his profession for twenty years. Dr. Provost was a member of the Winnebago County Medical Society, the State Medical Society and the American Medical Association.

Dr. Merten R. Streeter, of Oshkosh, died at his home May 2nd, of nephritis. He was born in 1860 and lived in Oshkosh all his life, excepting the six years he practiced at Bellingham Hospital. He was a graduate of the Rush Medical College.

Dr. R. G. Floyd of Eureka Springs, Arkansas, died June 17th. He was a former Wisconsin man, having been born in Berlin, Wisconsin, July 30, 1851. He graduated and practiced at Whithall. He later left the state and practiced in Colorado and Arkansas until his death.

If the spittle of him that hath consumption, being cast upon the coals, doth stink, and the hair fall from his head, it is a sign of death. (Hippocrates. Aphorisms.)

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOWALL, M. D.

MADISON

The time has come when a good laboratory service is essential to all pheysicians. Laboratory diagnosis is not intended to take the place of clinical diagnosis. It is simply an adjunct. When properly used a laboratory can be made of inestimable value to the physician in handling his cases. There are not a few, however, who expect far too much of chemical and bacteriological procedures. As a matter of fact the success which can be obtained in a laboratory doing diagnostic work depends largely upon the one who collects the specimen. The physician is frequently disappointed with the report received from the laboratories because he himself has not taken the proper precaution either in collecting the specimen or in having it transported. I have felt for a long time that we could render much better service if we could get closer to the physicians of the state and let them understand better exactly what our limitations are and also how they can help us overcome many obstacles.

In these days when it is so necessary that all the facilities in the state should be used to the best advantage for the cure of the sick and the preservation of health the laboratory service of the state wants to bring the full effect of its usefulness to every community. To carry out this desire it has been arranged that a portion of each issue of the Journal shall be devoted to giving information concerning our work and how the laboratories can be used. A part of the space which the editor has so kindly allowed us will be given to answering questions concerning the laboratories and other public health problems.

Considerable preparation has already been made to establish a State laboratory service. The first consideration, however, has been the proper control of communicable diseases. In order to exercise their full usefulness in this work laboratories must be located convenient to all, and so that specimens can be received in a few hours after being collected, and so that the report of the results of examinations can be received by the physicians with as little time interval as possible. For these reasons the laboratory located in Madison can not be of great service to all parts of the state. In

order therefore that all communities will be in easy reach of a laboratory a system of State co-operating laboratories has been established. Carrying out this plan, laboratories have been established in Superior, Rhinelander, Oshkosh and Kenosha in addition to the central laboratory in Madison. The director of the central laboratory has supervising control of all the others.

These laboratories are to assist physicians, health officers, veterinarians, and public health nurses, in carrying out measures for the control of communicable diseases and to aid physicians in their practice. The various problems of communicable disease control and laboratory diagnosis will be discussed in these pages. The early diagnosis of a communicable disease means the early erection of a barrier to the spread of that disease. The benefit of an early diagnosis accrues alike to the patient, the physician, and the community. The laboratory very often affords the means of the earliest diagnosis.

Sickness is to be dreaded at all times but especially so these days. Many of the physicians have been called into the service of the army. The best fighters against disease being away in the army, many weak spots are left in the line through which disease may enter. Greater care must be exercised than ever before. Disease at home means disease in the army. The soldiers are watched carefully. Their health is being guarded even better than when they were at home. It is the duty of those who stay at home to take every precaution to prevent disease from spreading at home, and from there into the army. The laboratories offer an early diagnosis, and therefore an early prevention to the spread of some of these diseases.

While the first purpose of our laboratories is to assist in the prevention of communicable diseases, that is not the only purpose. We are ready to do any examination which will aid the physician in making a diagnosis. We examine sputum for tubercle bacilli and other organisms, throat swabs from suspected cases of diphtheria and other diseases, blood from suspected cases of typhoid and paratyphoid, pus smears from suspected cases of gonorrhea and other diseases, cerebrospinal fluid from suspected cases of meningitis, the central nervous system of animals from suspected cases of rabies, specimens from suspected cases of anthrax, actinomycosis and glanders, feces and urine, make cultures of pus and other material to identify the bacteria present, prepare autogenous vaccines and make sanitary chemical and bacteriological examinations of water. Blood smears are examined for malaria and differential counts are made. The co-operative laboratories examine tissue for pathological conditions, and do milk analyses for the cities in which they are located. Typhoid and typhoid-paratyphoid vaccines are distributed free of charge to physicians. No charges are made for any examinations which are done in these laboratories.

We who are working in the laboratories see every day the necessity of better acquainting those who send us specimens with our methods so that a better co-operation can be carried out. You who send the material doubtless see the necessity of our being more and better acquainted with your needs. We hope this getting together can be accomplished through the pages of this Journal.

COURSE FOR PUBLIC HEALTH WORKERS.

A new type of public health worker is to be added to the forces which are combating preventable disease in Wisconsin if college bred women or others equally well equipped educationally are responsive to the large opportunity for service afforded by a new and original project of the Wisconsin Anti-Tuberculosis Association which is now well under way. Supplementing the efforts of physicians and nurses, this new worker, the trained health instructor, is destined, it is believed by those who are responsible for this revolutionary plan, to become a vital factor in protecting the growing youth of the state from the remedial physical defects which have disqualified so large a percentage of America's young men for military service.

The course of training to fit well-educated young women for this specialized line of patriotic service will be inaugurated in Milwaukee in September under the personal direction of Dr. E. V. Brumbaugh, whose experience as a public school teacher, principal, superintendent, medical school instructor, expert epidemiologist, and public health department official fits him most admirably for the work of familiarizing his students with the fundamental principles of health conservation and disease prevention. He will have as faculty assistants a number of the leading public health and

social service workers of the state, the Wisconsin Anti-Tuberculosis Association having the co-operation of the University of Wisconsin Extension Division, the State Departments of Health and Public Instruction, the Wisconsin Industrial Commission, and of the various Milwaukee health and social service agencies in the giving of its training courses. College and normal school graduates, young women with teaching experience or well founded in the technique of teaching, are now being recruited for the course. Only women of a superior type are desired for this important pioneer work and the first class will be limited to fifteen members in order to insure the most thorough individual instruction both in the class room and in the field work.

Wisconsin's urgent need for more public health workers, a need which it has in common with other states in the union, a need existing before the United States entered the war and intensified now by war conditions, is immediately responsible for the launching of this new project. On the one hand, doctors and nurses must be sent abroad in steadily increasing numbers. On the other there is the insistent demand for workers to protect the civil population at home. The need for instruction in health problems, for the protection of communities against epidemics, was never so keenly felt as at the present time when the entire country is aroused to the fact that conservation of human life is the most important problem of every community. The majority of the men and women who have been leaders in the public health work of the state are in military service. Their places are unfilled and to a large extent must remain so.

Alive to the seriousness of this problem because of the active part which it has taken, first in creating a demand for public health nurses throughout the state and then in training graduate nurses of recognized standing for community service and placing them in the field, the Wisconsin Anti-Tuberculosis Association early recognized its obligation in the new crisis confronting the public which has come to look to the state association for competent health workers. Even before awakened public minded men and women began to flood the association with frantic appeals to "do something" to help in solving the tremendous problem of providing the army with the best medical and nursing skill available and of safeguarding at the same time the workers and the children at home, the association's forces were busy formulating a constructive response to this appeal. It realized that it must continue with renewed zeal the courses for the training of public health nurses which it has conducted for the last three years and from which more than fifty persons have gone out into community service. It must carry on this work and redouble its campaign to enlist private duty nurses for the wider field.

Manifestly, however, this would not be enough. The nursing profession cannot begin to meet all the demands made on it even with the self-sacrificing return of those who have retired to private life. It cannot train student nurses fast enough, even with increased capacity in all the training schools and the establishment of new training courses in military hospitals, to supply a sufficient number of graduates for the various fields which are clamoring for them. Readjustments for the conservation of nursing skill are as imperative in the public health field as they are in hospitals and in the home care of private pay patients.

Out of the realization of this need to release, as far as possible, the services of the trained nurses for those positions in public health work at home and abroad and in military and civilian hospitals where nursing technique and skill are absolutely essential and out of the further realization that the public health worker of the future must be primarily and pre-eminently a teacher whose principal function shall be to guide the community in the right methods of hygienic living, came the conviction that a new source of supply must be found and a new type of public health worker developed. If, as will be granted without question, public health work and preventive medicine are educational movements, why not look to the educators for this supply? Teachers are already taking an important part in the public health work of the state. Why not train some of them to become health specialists? If the nurse could be taught some of the functions of the teacher and of the social worker to fit her for public health work, why could not the teacher be taught to detect and to guard against disease dangers, to do, in short, the kind of work that is now done by the great majority of public health nurses?

The establishment of the course of training for health instructors was the logical result. No attempt will be made to give these young women any instruction in the principles of nursing as they

relate to the bedside care of the sick. They will be made familiar, however, with the aims, ideals and methods of the modern health department. They will be taught the sources and modes of infection with special emphasis laid on the control of infectious disease and special attention paid to the carrier problem, the tuberculosis problem, infant hygiene and physical defects common among school children. Fundamentals of social service will be given an important place in the ten months' course, all of the instruction being given with the purpose of endowing the worker with the power to see her daily work, whether it be in school inspection, as an assistant in a city health department, or in an industrial welfare department, from the public health viewpoint.

In view of the fact that Wisconsin is so largely a rural state, special attention will be given to the problems of rural health instruction. There will also be a brief course in elementary anatomy and hygiene.

One-half of the course will be devoted to actual field work; each pupil being assigned to not less than four weeks of service in each of the various departments of tuberculosis, child hygiene, communicable disease, industrial and factory welfare, school inspection, probation and truancy field work. At the outset they will act as observers and then they will be assigned to do regular work in a limited district under the supervision of the regularly organized department. Each pupil will be held fully responsible for the work entrusted to her.

A tentative outline of the plan has called forth cordial approval from prominent public health men and educators in all sections of the country. So impressed with its value were the leaders in Minnesota that arrangements have been made to institute a similar course in the state university.

THE SERIOUSNESS OF VENEREAL DISEASE. By Sprague Carleton, M. D., F. A. C. S., 67 pages, cloth, illustrated. Paul P. Hoeber, publisher, N. Y., 1918. 50 cents.

This is a reprint of a limited edition arranged as a gift for the use of Base Hospital No. 48. It is a little manual of splendid illustrations explaining the subject to lay people. It asks and answers the questions: "Can You Afford to Expose Yourself to Venereal Diseases," and "Having Contracted Venereal Disease, Can You Afford Not to Take Advantage of Effective Treatment." It should prove of great value placed in the hands of our young men. Those wishing to distribute the book can secure it in large quantities from the publishers.

HIS OWN MEDICINE.

Once upon a time there was a doctor in the A. E. F.

Once upon a time there was a driver of that Ford.

The Ford and its driver were detailed to take the doctor from his station to a nearby town. The trip was made without mishap, but on the return the Ford gasped, wheezed, sputtered and died down.

The driver got out. He monkeyed around with the Ford's innerds for a long time; nothing doing. The doctor, being of a nervous temperament, teetered up and down beside the car, in a flurry of anxiety.

"Oh, what shall we do? What shall we do?" he exclaimed.

"Do?" snorted the driver, "Do?" "WHY, PAINT THE DAMN THING, WITH IODINE AND MARK IT DUTY!"

"HOW TO KILL AN ASSOCIATION."

1. Don't come.

2. If you do come, come late.

3. If too wet or too dry, too hot or too cold, don't think of coming.

4. Kick if you are not appointed on a committee, and if you are appointed, never attend a committee meeting.

5. Don't have anything to say when you are called upon.

6. If you do attend a meeting, find fault with the proceedings and the work done by other members.

7. Hold back your dues, or don't pay them at all.

8. Never bring a friend who you think might join the association.

9. Don't do anything more than you can possibly help to further the association's interests; then, when a few take off their coats and do things, howl that the association is run by a clique.

Affrick breedeth the Hyene, which beast cannot wrythe his neck aside, unlesse he moove his whole bodie, because hys backbone is without joyntes, and runneth so whole through hys necke. Manie wondrous things are reported of it. First, that it haunteth shepheards cottages, and by continual harkening, learneth some name, the which he expresseth by counterfitting mans voice, to the intent to work his wrath upon the man whom he tolleth forth by his policie in ye night time. Also he counterfetth the vomiting of men, and thereby alluring out dogs with his false sobbing, devoureth them. Which dogges if perchance they touch hys shaddowe in hunting of him, they lose their voyce, and cannot barke. And in their eyes is found a stone called Hyenie, which powdered and taken upon the tongue maketh him that taketh yt to prophesie of thyngs to come.

—Caius Julius Solinus.

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BOOKS RECEIVED

A Treatise on Clinical Medicine. By William Hanna Thomson, M. D., LL. D., formerly Professor of Practice of Medicine and of Diseases of the Nervous System in the New York University Medical College; Ex-Vice President of the New York Academy of Medicine, etc. Second edition, revised. Octavo volume of 678 pages. Philadelphia and London. W. B. Saunders Company, Philadelphia and London, 1918. Cloth, $5.50 net.

Long Heads and Round Heads. A study of "What's the Matter with Germany," by Dr. W. S. Sadler of Chicago. 157 pages, illustrated. Cloth, $1.00. Published by A. C. McClurg & Co., Chicago.

Military Surgery. By Dunlap Pearce Penhallow, S. B., M. D., Major, M. R. C., with an introduction by Sir Alfred Keough, K. C. B. Second edition, revised. 555 pages, illustrated. Published by Oxford University Press.

Burns and Their Treatment including Dermatitis from High Explosives. By J. M. H. Macleod, M. A., M. D., F. R. C. P. 160 pages. Cloth, $2.00. Published by Oxford University Press.

Lessons From the Enemy, By John R. McDill, M. D., F. A. C. S., Major, M. R. C., U. S. Army. This the War Manual No. 5 published by Lea & Febiger, Philadelphia and New York. Cloth, 262 pages. $1.50.

Laboratory Methods of the U. S. Army. Compiled by the Division of Infectious Diseases and Laboratories, office of the Surgeon General, War Department, Washington, D. C. Illustrated. War manual No. 6, Lea & Febiger, Philadelphia and New York. Cloth, 256 pages. $1.50.

The Practice of Pediatrics. By Charles Gilmore Kerley, M. D. Second Edition, Revised and Reset. Octavo of 913 pages, 136 illustrations. Philadelphia and London. W. B. Saunders & Company, 1918. Cloth, $6.50 net.

Since the previous edition of 1914, twenty-five new articles have been added, sixteen chapters largely rewritten and lesser changes made in many others. Much old material has been removed and in its place has been substituted new material which will be of service to student and practitioner. The work begins with the newly born and completely covers every phase of the subject throughout the childs development to the adult state. The chapters on Nutrition and Growth, Diseases of the Respiratory Tract, Nervous Disorders and Therapeutic Measures should be read by every physician whose practice brings him in contact with children. The work is well written, easy for reference purposes, very complete on all subjects and is well illustrated. It is a practical and valuable work for the general practitioner.

Diseases of the Chest and the Principles of Physical Diagnosis. By George W. Norris, M. D., Assistant Professor of Medicine in the University of Pennsylvania, and Henry R. M. Landis, M. D., Assistant Professor of Medicine in the University of Pennsylvania, with a chapter on the Electrocardiograph in Heart Disease, by Edward B. Krumbharr, Ph. D., M. D., Assistant Professor of Research Medicine in the University of Pennsylvania. Octavo volume of 782 pages with 413 illustrations. Philadelphia and London. W. B. Saunders Company, 1917. Cloth, $7.00 net. Half Morocco, $8.50 net.

There have been a number of books written within the past few years dealing with diseases of the lungs and heart. To project still another book on these subjects seems to presuppose no little temerity on the part of authors.

We must confess, however, that the work under review written by the two Philadelphians is different from any which it has been our privilege to review. We have been hoping and longing for something which would show a distinct tendency to break away from old forms of book writing. Very many books which we have seen on these subjects are so much alike that only the authors' names, the color of the binding and the names of the publishers serve to distinguish one from the other. Even gross errors are handed down from book to book.

In a careful perusal of the book by Norris and Landis we are glad to say that a new note has been struck. The book is divided into four parts. Dr. Norris in the first two parts discusses most fully and lucidly the examination of the lungs and the examination of the circulatory system. The chapter on "Acoustics in Physical Diagnosis" is unique. We heartily agree with Dr. Norris that, "only through the comprehension of the laws of sound production and transmission can the results of percussion and auscultation be intelligently interpreted." In Part II a chapter on "The Electrocardiograph" is writen by Dr. W. B. Krumbhaar.

Dr. Landis in his Parts III and IV discusses "Diseases of the Bronchi, Lungs, Pluma, and Diaphragm" and "Diseases of the Pericardium, Heart and Aorta".

A feature of the book, aside from the actual text which is well-written, is the truly wonderful collection of illustrations. Those of the frozen sections of chests presenting various pathological conditions should better than any number of words show the actual relations of the parts and should prove of immense help in the interpretation of such processes when found in patients.

It has been a pleasure to review this book. The authors are to be congratulated upon producing such radical text in such a masterly manner.

The bookmaking is splendidly done. All the illustrations are beautifully reproduced. We, Reviewers, often say perfunctorily that such and such a book should be in the hands of every physician. This Reviewer says it now but with the punch of absolute sincerity behind it, for we really know of no book which presents the subjects written of in this book in a more attractive and authoritative manner.

L. M. W.

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ORIGINAL ARTICLES

THE USE OF PRECISE METHODS IN MEDICINE.

BY H. P. GREELEY, M. D.,

MADISON.

Medicine differs from all the pure sciences in that it deals not only with those branches of scientific knowledge that we can call pure sciences such as anatomy, pathology, chemistry and physiology and the like, but it also deals with a living being that has individuality, feelings, emotions, that have to be reckoned with. The pure scientist never has to consider these for he deals with dead matter, the reaction of which follow physical laws only. The practitioner must exercise art and tact in the handling of the sick patient. The physician who pursues his profession as the scientist performs his studies and laboratory work will never have the love and admiration of his patients. It is the scientific impersonality in medicine that strikes the American physicians forcibly in their contact with continental practice. It is the lack of appreciation of the scientific attitude in medicine that has always made the continental physicians hold us in little esteem. It is the proper balance between the practice of medicine as an art and the practice of medicine as a science that makes the best and greatest type of physician. We have all wondered at the miserable failure made in practice by some of the graduates of highest academic standing, and we are all too familiar with the great success that the most ignorant practitioner and quack can attain if they know how to handle human nature with tact and sympathy. Such men are often self-deluded and their sincerity cannot always be impugned.

It is necessary for the truly successful physician to combine a sympathetic consideration of the individual with the scientific study of his disease.

The scientist has in the past too often regarded the practitioner as a careless and unscientific worker and the practitioner has too often perhaps, reciprocated by regarding the scientist as an impractical theorist. Consequently the relations between the two have seldom been as intimate and cordial as would have been to their mutual advantage.

Another reason for the attitude of the practitioner of medicine toward the scientist is that the art of medicine preceded the science of medicine by several thousand years and for generations the scientist was fought off as an intruder upon the vested rights of the practitioner. We have, of course, long since outgrown this attitude but it no doubt retained some considerable influence for a long period as an unconscious force and prejudice.

Revolutions can and do take place almost over night in our knowledge of the science of medicine, but changes in the practice of medicine are always painfully slow and evolutionary. A revolution in medicine accompanied the knowledge of the infectious diseases, but the application of this knowledge to medical practice has been slow in arriving. Even today medical practice is not free from the unscientific parlance of the age before bacteriology. People are still encouraged to believe that they "catch cold" in cuts and injuries and teeth when, of course, it is the bacteria from the air or the bacteria in their tissues and not the exposure to the air that is responsible. "Night air" has not yet been recognized as a harmless necessity, instead of a danger to be avoided. Phrases such as these are of no consequence other than that they do obstruct progress like the barnacles on the bottom of a ship and it is one of the important functions of the medical profession to put its ship of progress into dry dock every year and scrape its bottom clean of the barnacles of tradition and prejudice.

And so it is that practicing physicians after many years are in the position now where they fully realize the value of applying to medical practice the scientific advances in bacteriology and chemistry. No practitioner now fails to appreciate the value of accurate laboratory diagnosis in

*Read before the Dane County Medical Society, March 12, 1918.

Diphtheria, Tuberculosis, Typhoid, Gonorrhea, Syphilis, Malaria, Meningitis and other infections of known causation like Glanders, Rabies, Actinomycosis, etc. A routine swab culture from the nose or throat in inflammation of the upper respiratory tract often meant more than anything else to the patient and the physician and it is less time consuming than writing a prescription in communities like this, where laboratory facilities are at hand. These methods of diagnosis are now an integral part of medical practice, without which we would feel completely at a loss. It is unnecessary for me to go over any of these laboratory tests which aid us in diagnosis and treatment since they are familiar to all and employed by all every day.

In reading our journals, however, there are an ever increasing number of new developments in the use of precise methods and as practitioners we are often at a loss to know their real practical value. If we accept the enthusiastic reports of the early laboratory workers, which are too often hopes, rather than realizations, we suffer frequent disappointment and may even become so critical that we fail to grasp what little of real value there may be.

As soon as any of the newer advances has stood the test of experience at the hands of a few of the most reliable workers, we ought not to fail to use it, but in using it we must not expect too much. Let us accept such advances at their real value and let us look not for panaceas. A negative result is as valuable often as a positive one.

Among the more recent achievements from which we can learn something of practical value and which we can use here in Madison, is the work on Pneumonia, mainly carried on at the Hospital of the Rockefeller Institute. Taking the most conservative attitude possible the following is true.

By determining the type of organism, which is done by sending fresh sputum to the State laboratory, we can give a more accurate prognosis. For instance: In Type IV infections, the prognosis is uniformly good. In Type III almost uniformly bad. In Type II there is 25 per cent mortality. So also with Type I, but the mortality in Type I infections can be reduced 66 per cent or to 8 per cent if Type I serum is properly administered. If your case is doing badly and there is a continued bacteremia which we can determine by blood culture, the prognosis is also decidedly bad; but perhaps the most important conclusion to draw from this work is this.

Since Type IV organisms are the only ones commonly found in health in the upper respiratory tract, all cases of Pneumonia should be put on precautions with as great care as any case of Tuberculosis. Types I, II and III organisms are passed around presumably by direct contact and proper precautions would markedly cut down our winter morbidity rate; especially if they were combined with a careful determination of convalescent carriers and their control.

Aside from this work in Pneumonia, Rosenow's work in Infantile Paralysis will place another responsibility of prompt and precise action on our shoulders. If the success of his work at Davenport, Iowa, is borne out by future experience, prompt action will save from being cripples a large army of children, besides the greater saving of life.

Volumes have been written upon the use of the X-ray and so in speaking of its value as a precise method in diagnosis it is not my intention to do anything but urge its wise employment by all and by using it as an example call your attention to the unfortunate results that sometimes follow the adoption of precise methods. The surgeon, trained in the use of the knife—an instrument of precision of the highest order—has been more ready to adopt other measures of precision than the physician, whose traditional dependence upon prescriptions and pills has not trained him to the same degree in precise methods. So with the surgeon the more ready adoption of precise methods has carried him further afield and resulted in the concentration of ability along special lines and the development of the large number of surgical specialties, for specialties always result from the extensive development of specialized methods of precision. The advantages of this development are not open to serious question. The disadvantages are the result of human frailty, so in the use of the X-ray in particular, the tendency has been among many to put too great a dependence on the picture and neglect the thoughtful study of the case. Important as the X-ray is, it is not always dependable and should be used in medicine as an aid to diagnosis but not as a sole means of diagnosis, to the exclusion of a most careful clinical consideration of the case. The surgeon is a specialist and this is true of all specialists, as such,

he must be careful not to lose any perspective, but try to always maintain a true sense of values. I think we have passed the critical period and that now all specialists realize the need of careful medical study in their cases.

I cannot leave the consideration of the X-ray without mentioning its value in general medicine in one particular field, not fully appreciated, I think, yet. I refer to focal infections and apical abscesses of the teeth. It is not necessary to take an extreme view and attribute all systemic disease to focal infections, but it is necessary to wipe out completely every infection in the body wherever it exists. The damage that tooth infections cause in any given case may be problematical, the damage that it can cause in any given case is almost unlimited. Take as an example the case of a woman at about the menopause, whose bowels are sluggish, who shows a tendency to put on weight and who has bad teeth with apical abscesses. Don't wait for that woman to have gall stones, ulcer of the stomach or appendicitis and so compel a surgical operation, but rid her system of all portals of entry for bacteria and so reduce to a minimum the possibility of their entrance into the system. The X-ray of the teeth is a permanent step ahead in modern medicine.

The use of the X-ray in Gastro-intestinal disease, in accurate determination of the exact size and shape of the cardiovascular system and in the early diagnosis of Tuberculosis are indispensable aids to our armamentarium. I do not know why it is that the general practitioner has not availed himself more of the X-ray unless it be the disproportionate fees that this work has always commanded.

Passing on we come to a very broad field of medicine to which great study has been given and great advances made in recent years. The study of the alterations in the chemical nature of body fluids in the field of metabolism has been voluminous. So much so that we find ourselves in a confusing maze of detail, from which it is difficult to choose the wheat and leave the chaff.

The study of metabolism in the normal has shown us the importance of feeding the human body. The only practical way of influencing body chemistry is through the food. There is considerable evidence to show that among the faulty habits which contribute to the onset of the so-called degenerative diseases, Diabetes, Bright's Disease, Gout, Obesity, and Arteriosclerosis, faulty habits of eating are not the least important. It is in the application of our knowledge of nutrition to the healthy and normal individual (from the point of view of his metabolism) that we can expect good results. The employment of scientific feeding as a precise method in prophylaxis and therapeutics is imperative. Too long have hospital and home dietetics been based on habit, ignorance and whim. Little or no scientific thought has been given in the past to hospital diets except in gastro-intestinal disease and fevers like Typhoid. Patients have been routinely starved before operations and then passed on to "liquid" and "soft solids" and finally to "general diet." It has been left to the discretion of untrained persons to choose these diets. Within a short time a member of my family was served boiled ham and fried bananas four days after an abdominal section. Good food for a laborer but hardly the thing for a person who could not turn over in bed. Precise and rational dietetics will hasten convalescence, prevent complications and make people a little more ready to go to a hospital. It is almost a general feeling among the laity that you can't get anything fit to eat in a hospital. The war has greatly stimulated the study of nutrition and is contributing much to rational, simple, healthful dietetics. If we fail to make permanent, when peace comes again, the lessons of the war in regard to rational eating, we shall lose one of the greatest opportunities so dearly bought by the war.

When it comes to the study of actual disease we find that a great many of the disturbances in metabolism are due to the abnormal production of acids in the body and the consequent withdrawal of bases producing a condition that is called acidosis, which is, properly speaking, a condition of reduced alkilinity, as the body fluids never actually become acid in reaction. The clinical recognition of moderate and slight degrees of acidosis require the employment of special tests.

The commonest conditions in which acidosis arises are perhaps nephritis and diabetes but the condition is by no means restricted to metabolic disease. Acidosis plays an important rôle perhaps in shock and certainly in many post operative conditions, some of which have hitherto been of a most perplexing nature. It is now recognized that some cases of hiccoughs, dilation of the stomach, vomiting, delirium and stupor following operation,

are due to acidosis. And so it is that surgeons no longer starve their patients before operations but give them plenty of carbohydrate food and often combine this with the giving of some alkali. Again by careful urine and blood analysis they are able to determine an impending acidosis which might have assumed a severe type unless checked.

In Nephritis, in diagnosis and prognosis the renal function tests, chief of which for practical purposes, is the sulphonphenolphthalem test, as of the greatest assistance. This test is most simple and easily carried out and is free from any objection whatever on the part of the patient. Together with repeated and careful estimations of blood pressure, systolic and diabolic and pulse pressure, the renal function test adds decidedly to our knowledge. A much more detailed study of the intake of food by test diets and the outgo of metabolic products is unnecessary for the general practitioner and cannot be done outside of a hospital. Too much emphasis has been placed upon the presence of albumen in the urine. In the most severe cases it is often absent and in mild cases no occurrence is of only minor importance. Too little emphasis has been put on the rate of elimination of urine, the day and night quantity excreted, the changing gravity under different circumstances or the constancy of the gravity in severer chronic disorders.

In many acute and sub-acute Nephritic states, it is of the utmost importance to determine the ability of the kidney to excrete salt, as in no other way can you control some difficult and obscure cases. Chemical examinations of the blood for retained products of purin metabolism are not worth while unless the patient is in a hospital where the intake and outgo of food products are known accurately.

In treating Diabetes accurate control by careful chemical analyses of the blood and urine combined with precise feeding is indispensable. So much has been written in the last few months that I presume the subject is a familiar one but since my experience has led me to a more careful consideration of this disease I will give you a resumé of the methods of control which are most valuable. As Dr. Allen no doubt told you when he was here in the fall, he does not consider the urine examination at all adequate in the guidance of treatment of a diabetic. In his experience and in that of all internists patients may remain sugar free and acid free as to their urine and apparently be getting worse all the time, the progress of the disease downward only being brought to light by a sudden calamity. Consequently it is our aim to have our patient's blood sugar normal and to have the blood free from acid bodies as well as the urine.

It will probably also be necessary in the future to check up the blood fat content as this may be an isolated sign of the improper management. Just how far blood examinations will replace or supplant in importance urine examination as the chief guiding factor is still problematical but at present it seems very necessary. This is because we are at that unfortunate stage in our knowledge of Diabetes where enough is known to make management fairly complicated and when conceivably a little more knowledge might make it very simple. It is considerably more exact than it was and our results are at least 75 per cent better than they were before.

We are so much better off because by repeated blood examinations we can always be advised of impending coma in time to prevent it. Coma in uncomplicated cases of Diabetes reflects upon the physician. The newer methods of the determination of alkali tolerance, blood carbon dioxide and the alkali reserve of the blood are relatively simple and are coming into use more and more. The management of Diabetes is dependent as much upon the intelligence and co-operation of the patient and dietetian as upon the skill of the physician. The precise methods of feeding have changed as much as the chemical methods of control. Just a few years ago the restriction of carbohydrate was all that was attempted. Then came the knowledge that protein was a very generous source of sugar and so protein had to be restricted. This left our patients with only fatty foods to fall back upon and they rapidly developed acidosis if left to themselves, so then we restricted fat and now we have to feed our patients purely on their bodily requirements. If their age, weight and work necessitates for them 2,500 calories they must have that amount and no more. It is the question of the gasoline engine again and the proper mixture of gas, air and oil, just the right amount of each is required, neither too little or too much.

In this fragmentary review, I have intentionally avoided any description of methods. They are dull and uninteresting and so easily obtainable that it is useless to reprint them here. My pur-

pose has been rather in a general way to point out the changing attitude of the profession toward precise methods and in conclusion I want to say that this attitude is not toward laboratory methods alone but to the greater and greater care that must be exercised in the precise methods of history taking, physical examinations and the accurate tabulation of findings and keeping of records, the importance of which, in clinical medicine, is in this age underestimated.

Much as has been the great gain in accurate and early diagnosis and the consequent application of specific measures in treatment and prevention through highly developed and specialized technical laboratory methods the field of investigation in clinical medicine and the need for careful and thoughtful study of signs and symptoms and their proper recording is by no means a sterile or unprofitable one.

Nowhere is this more clearly brought out than in the work of Mackenzie on the heart and I want to quote what he has to say in this connection himself. "But it is only a very small proportion of the sick who visit a hospital. It is the general practitioner, who sees disease in its early stages, who has the opportunity of finding out what conditions predisposed to the disease and of following it through all its stages.

"This need for the general practitioner as investigator which I am certain will, in time, become self-evident, is, at the present day, not realized. The domination of the laboratory is so great that the whole tendency is now to be ruled by the conception of the laboratory worker. If you will reflect, you will realize that a method of selecting as teachers of medicine men who can have no knowledge of the aspects in which disease will present itself to the vast majority of their pupils in future life is utterly indefensible. There is a vast difference between hospital and general practice. Such teachers, with their limited training, are practically unconscious of the great opportunities for the advancement of medicine which their pupils who go into general practice will have.

"My purpose in insisting in this lecture upon the necessity for accurate study of the patient's sensations, and for the utilizing of the opportunities of the general practitioner, is to demonstrate that, in clinical medicine, methods of research must be adopted that are peculiar to this branch of science. I have heard it repeatedly stated by leading members of our profession that the limits of clinical medicine have been reached, and that no further progress can be made until new methods have been discovered. This belief is widespread, and we see its effect in the sudden rush which is made after any new mechanical device. Now I want to impress upon you the fact that the means of investigation which we possess in ourselves, without the use of mechanical devices, have not yet even been begun to be employed on a scientific basis.

"As yet we scarcely perceive the limitations of laboratory methods. You can readily understand that in the discovery of the mechanism of some obscure process, laboratory experiments are essential; but to find out what bearing that obscure process has upon your patient's future life is quite another matter. Nevertheless, it is a matter essential for you to know. It follows, then, that research in clinical medicine must pursue lines of its own; these lines are not the loose, speculative ones of bygone days, but the precise and accurate observations on living individuals by means of which alone knowledge of real value can be obtained."

Here we have the combination of which I spoke in the beginning, the man who unites with the careful consideration of the individual the scientific study of his disease.

It is no wonder that the profession of medicine is considered a difficult one, but I tell you that all the old time drudgery of the profession is turned into zest and enthusiasm if only one gets the "inquiring spirit."

It is possible for each one of us to be an investigator if we can cultivate the inquiring spirit and adopt a hobby. In the midst of a general practice we can make of some condition or disease a special intensive study, making ourselves more proficient and attempting to add something to the sum of knowledge in that particular field. The sinequa non of progress is concentration of effort and co-operation in the development and application of precise methods of investigation and treatment. It is what gives zest to the practice of medicine and what ennobles it above the other professions in that we are all working together for the common good. It should be our real happiness either to make some contribution to the science of medicine or if that is not granted us to inspire others to do so.

THE RELATIONSHIP OF TEMPERAMENT TO THE PSYCHOSES.*

BY A. W. ROGERS, M. D.,

OCONOMOWOC.

It is impossible for one with an inquiring frame of mind to live in daily contact with certain conditions over a period of years without reaching certain conclusions, and, while I have made use of some quotations, the substance of these remarks is the result of my personal observation, and I present these conclusions for your criticism and discussion.

In taking the history of an individual broken down nervously or mentally, the layman, and too often the attending physician, inclines to fix upon some one cause. It can be truthfully said that this is practically never the case since careful investigation brings to the surface a combination of causes, and back of the whole picture lies the individual's make-up or temperament. It has been said that each individual has his or her breaking point, but how greatly this varies! Each of us react differently to the same stimuli and this is chiefly because of temperament. Just what do we mean by temperament? The ancients held that temperament is conditioned on the predominance of one of the four humours—the blood, lymph, yellow and black bile—in modifying or tempering the manifestations of the organic functions. Hence the temperaments were classified as sanguine, lymphatic, bilious and melancholic. The Standard Dictionary defines temperament as—"A special type of mental constitution and development due to natural characteristics of the bodily organism, often inherited."

The classification of temperament by the ancients has undergone little change with the passage of time. Some new terms are used to describe the same condition. Our knowledge of its origin and development, however, has been greatly illuminated.

It is not my intention, at this time, to consider temperament as observed in every day life, and under ordinary conditions, but rather, those extreme states in which volition is more or less impaired, the border line states approaching a true psychosis.

We are all familiar with the McCauber and the lugubrious blue types. There is no doubt but that the extreme optimistic and pessimistic types are equally incapable of forming sound judgments on any proposition in life.

One class of individual approaches every problem of life, large or small, with a feeling of confidence and ultimate success, which helps them to overcome almost insurmountable objects. This confidence is a wonderful human asset when balanced with good judgment and control, but a certain proportion of this class reach a point of undue mental exhilaration and euphoria, and they are unable to be seriously minded as occasion requires. Their mental state is one of pathological exaltation. They apprehend no trouble, no difficulties and no opposition. Though out of work, and with but a small bank account, they experience no anxiety as to their future. If attention is called to their undue optimism, they tell you they are all right and there is no occasion for alarm. There is an accompanying display of egotism, volubility and general mental expansiveness, but not necessarily any impairment of the higher mental faculties other than judgment. There is always a sense of physical good feeling, and the discharge of physical functions is excellent, with the exception of a usual insomnia. We are dealing, in these cases, with a vascular disturbance, manifesting itself in a mild cerebral congestion. Many of these patients come under the observation of the medical man for the persistent insomnia, and only too often the cause and nature of this symptom is misunderstood. The wave passes and often natural sleep reappears in a few days or weeks as quickly and unexpectedly as it disappeared, and in every other respect the individual returns to his natural condition. I have frequently had individuals come under my care for the relief of insomnia with the accompanying group of symptoms described above. Inquiry usually brings to light the fact of one or more previous similar attacks. In some instances the condition does not reach sufficient severity to materially interfere with the individual's work, but in the majority of cases, judgment is so warped, and the insomnia so depleting as to cause them to cease their duties for a time. These attacks not only differ greatly in their severity, but also as to frequency and length of time. I have observed cases in which the attacks appeared rather regularly every 3-5 weeks, and others only a few

*Read before the Milwaukee Medical Society, May 14, 1918.

times in a number of years. In some they last but a few days, while in others several weeks.

Just as we often observe the sanguine temperament tending to develop periodical states of exaltation, so we frequently find, implanted on the pessimistic temperament states of undue uneasiness and depression. The individuals experience a feeling of bodily lassitude, tire easily, have restless sleep, are bothered by depressing dreams—the effects of which are often carried into their waking hours. Appetite and other physical functions are usually off color. Mentally, they experience vague apprehension and varying degrees of unaccountable depression, lack initiative and the energy to attempt or carry through any enterprise. They are too easily discouraged by trifles, and are often overwhelmed by events, which the average person meets with pleasure. Recently a gentleman, 42 years of age, came to me stating that aside from some lack of physical energy he felt very well, but could not understand his state of mind. He proceeded to explain that he was conscious of an unexplainable anxiety, apprehension and depression which had come upon him like a cloud. He had to force himself to work because of the absence of his usual interest in it and that everything which usually amused and interested him, failed to do so. Inquiry brought to light the fact that several times in the past he had had similar experiences but not of sufficient severity to arrest his attention. The depression passed in the course of three weeks without any change in his external conditions, and without any apparent change in his internal make-up. The danger of suicide in this type has not been sufficiently realized. The unaccountable depression and apprehension, along with impaired power of concentration, frequently leads the individual to believe that he is losing his mind. This in turn, increases the depression, and they argue that it is better for them to die than to become insane. Personally, I think suicide is a very great danger in such cases.

While the two above described types are quite common, the most common is the cyclothymic temperament. Here we have an alternating period of depression and exhilaration usually with an intervening period of normality with freedom from either extreme. This type is no way differs from the other two, except in the tendency for the two phases to alternate and each phase being separated by a varying period of freedom from either depression or exaltation. These individuals usually sense their changing moods, while those about them are quite aware of their different states of mind. Many of them continue with their duties through these shifting phases, but some of them are capable of good service only in the normal interval. Permit me to illustrate this last type by citing the case of a gentleman, who has come under my observation on several occasions during the past two years:

A man, 44 years old, married, 3 children. No special unfavorable hereditary influences to be discovered but a satisfactory history on this point could not be obtained. This man has a high grade efficiency mind and able to earn a salary of $800-$1,000 per month when well. Thirteen years ago, or when thirty years old, under considerable pressure he had a nervous breakdown accompanied by marked insomnia, mild depression and some persecutory ideas. This condition cleared up in three months time. In the interval up to about two years ago, his wife states that she had never observed any abnormality in his mental processes outside of slight alterations in his moods which, however, were always accompanied by more or less troubled sleep, and sometimes rather pronounced insomnia. The chart which I place before you shows these alternating moods as I have observed him since September, 1917.

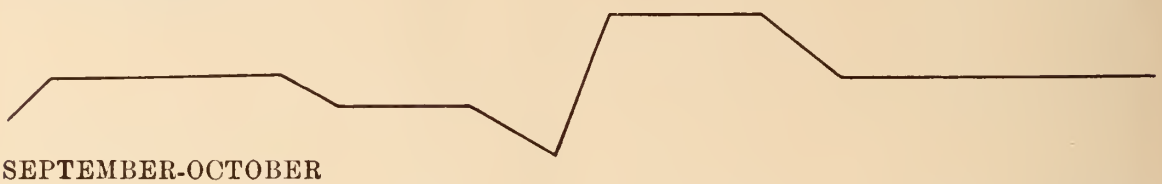
Dr. L. Pierce Clark, whose life work has been the study of epilepsy, has reached the conclusion that the idiopathic epileptic is born and not made, and that we must treat the epileptic and not the epilepsy. He states: "When one studies the majority of epileptic patients carefully, one notes the enduring presence of the physical and mental stigma of their peculiar make-up. Oftenest this antedates the very inception of their disorder, and cannot be properly charged solely to the seizure phenomena, as this personality and temperament as well as physique, most frequently date from birth."

It would seem that temperament and personality influenced not only the functional psychoses, but played an important role in the development of the organic mental disturbance known as paresis, although this form of insanity is invariably due to syphilis. There is conclusive evidence that the preparetic make-up or temperament of the individual influences the type or paresis. The naturally optimistic paretic develops the exalted and

AUGUST - SEPTEMBER, 1917. Below normal line, depression—above, exaltation.

28 29 30 31 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

* Normal mental state



SEPTEMBER-OCTOBER

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NOVEMBER

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DECEMBER

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

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JANUARY, 1918

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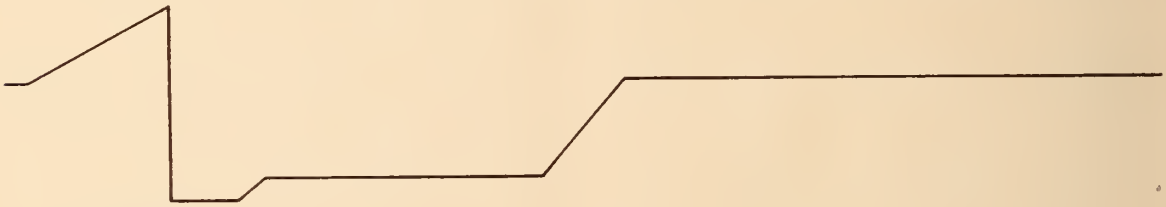

FEBRUARY

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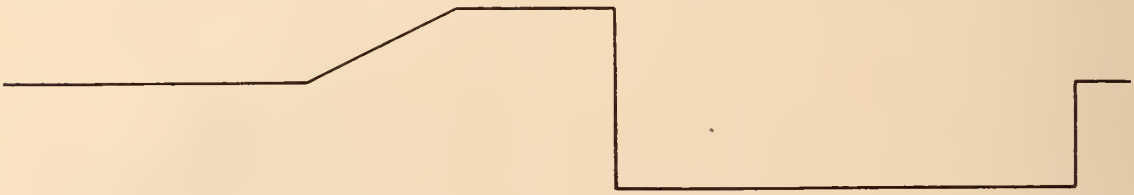

APRIL

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29

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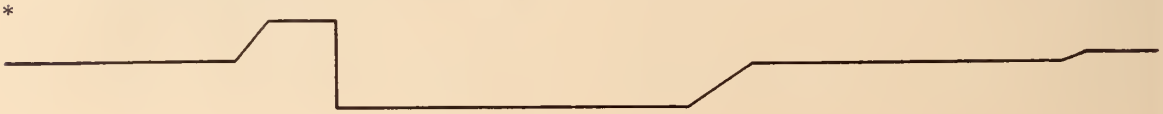

maniacal type, while the pessimistic the depressed type. Further, those individuals, who are normally neurotics and psychopaths are prone to develop mental symptoms when infected with lues.

Of paramount importance, at the present time, is the part temperament plays in the development of war psychoneuroses. No medical man in the service today is doing more valuable work than the neurologist and psychiatrist. Two thousand recruits are turned down each month because of some defect in the central nervous system. The government is attempting to reduce to a minimum, those individuals who later are liable to become shell-shock cases. "Wolfsohn" made a study of 100 cases of war psychoneuroses and 100 cases of somatic injuries produced in the firing line. He says that cases of war neuroses are very rarely associated with external or somatic wounds. The vast majority of the psychoneurotic cases studied were among soldiers who had a neuropathic or psychopathic soil. In 74 per cent of these cases, a family history of neurotic or psychotic stigmata, including insanity, epilepsy, alcoholism and nervousness was obtained, while a previous neuropathic constitution in the patient himself, was presented in 72 per cent. A gradual psychic shock from long continued fear, together with the sudden change from quiet, peaceful environment, to the extraordinary stress and strain of trench fighting, is the chief predisposing cause of war psychoneurosis in soldiers with neuropathic disposition. In fact, these factors may be the cause of the neurosis per se. The history of the patient, previous to enlistment, has an influence on the character and gravity of the symptoms of the neurosis."

In conclusion, we would state that we are firmly convinced that temperament is not only an index to the individual's future success and happiness, but also to his mental status. Pessimism and apprehension tend toward the melancholias: optimism toward maniacal conditions, while the cyclothymic to the manic-depressive or circular insanities. In short, a knowledge of temperament makes it practically possible to predict the type of psychosis an individual is liable to develop.

The essential feature of this whole problem is the early recognition in the child of its temperamental inclination. While we firmly believe that heredity plays a very prominent part in temperament, we also believe that much can be accomplished by parents, teachers and physicians in the moulding of the individual make-up through proper training and education.

SUB-MUCOUS RESECTION OF THE NASAL SEPTUM.*

BY C. G. DWIGHT, M. D.,

MADISON.

It should not always be expected by one one writes on an old subject, to present something new!

In looking up the literature on the "Submucous resection of the nasal septum" it seems that almost everything has been said on this subject; but, there comes a time when the old story has to be told again for the benefit of the rising generations. In telling it as DeQuincy has said: "Every man gradually learns an art of catching at the leading words that more clearly emphasize the Cardinaly points."

The sub-mucous resection of the nasal septum has gradually grown in favor as an operation for the relief of nasal stenosis. From the excellent results obtained by a large number of our nasal surgeons and carefully reported, one would think the operation merited universal adoption. This has not been the case, and there are many nasal surgeons today treating nasal stenosis in the same antiquated methods by sprays, cautery, operation on the turbinates, and worst of all by incomplete and imperfect septal surgery. There have been a goodly number of varieties of methods of operating the septum brought forth, and in fact, few surgeons can be found who use the same technique; each operator having some particular part of the operation which is his own idea. This has helped to make the operation unpopular, and I believe that it is time to standardize the operation for "sub-mucous resection of the nasal septum," so for lack of a better name, I have thought to call the operation by the name of the "radical" operation.

The radical operation does not consist of removal of a part of the triangular cartilage, leaving a portion of the perpendicular ethmoid plate, and the vomer yet curved and in contact with the middle turbinate, but it means to remove all of that

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*Read at the Meeting of the State Medical Society of Wisconsin, Milwaukee, October, 1917.

part of the nasal septum that is in apposition with either side of the outer wall of the nose.

There have been several varieties of incisions suggested, together with the all-skin incision. The most practical incisions suggested which have been universally used are the Hajek, Killian, Yankauer, and Freer "L" shaped. I have personally preferred one of the three former, according to the location of the curvature in the septum. For the septum that is deviated far anterior the Hajek is most suitable. Those with the curvature farther back, especially in the perpendicular ethmoid plate, the Yankauer is more suitable, and the Killian is more suitable where neither extreme of deviation presents itself.

Most operators have thought that it was advisable not to operate on the septum until after the age of fifteen years, because of the lack of bone development.

The operation is counter-indicated in acute inflammations of the throat, and acute suppurative processes in the ear, and further counter-indicated by diabetes, tuberculosis, syphilis; and a postponement of the operation is advisable in hemophelia and pregnancy.

We are all often tempted to combine a submucous operation with other operations, especially the resection of the middle turbinate, the removal of tonsils, and sinus operations. It should be laid down as a rule, I believe that simultaneous operations on the throat and nose of any considerable magnitude are not advisable. Loeb has said: "Combined operations within the nose may be performed, but the operator must expect a greater reaction and increased danger, dependent on the extent and character of the two operations."

The anatomy met in the sub-mucous operation is not very complex. The septum receives its blood supply from the naso-palatine, the anterior and posterior ethmoid and the septal arteries. The nerve supply is from the first and second branches of the trigeminus, the vidian and the naso-palatine branch from Mackels Ganglion. In the mucosa of the septum, in its upper segment, a large proportion of the ramifications from the olfactory bulb are situated.

I think the complete operation has been looked upon as a more difficult operation than it actually is, and the deformity necessary for operation has not been well understood by diagnosticians in general.

There are only three individual structures that enter into the formation of the nasal septum. The lower posterior portion is formed by the vomer, the upper posterior by the perpendicular plate of the ethmoid, and the remaining or anterior portions by the triangular cartilage.

By spraying both sides of the nose with a 3 per cent cocaine solution combined with a 1-5000 solution of adrenal, the membranes are shrunk quickly, so that a thorough inspection of the lumen of the nose can be made, and without this preliminary preparation a generally poor idea only can be obtained as to the exact position of the septum. I am making this plain, because I feel that not enough care has been taken in examining the upper portions of the nose. That part of the perpendicular plate of the ethmoid which lays opposite the anterior one-half of the middle turbinate is often overlooked, and this is the one important part of the deformity of the septum, which I wish to clearly emphasize.

Since I thought of writing this paper last January, I have done more than eighty sub-mucous resections. A careful classification has been made of these cases by my office nurses, and it is very remarkable to follow the symptoms that these cases were suffering from.

There was a special type that lacked oxygen, that ranged from 19 to 40 years of age. In this type the septum was widely deviated, practically closing the right or left nares. They complained of not getting enough air. They were anaemic and easily tired out.

There was a type that complained of posta nasal discharge. The septum would be broken and most of them had a thickened septum with a ridge far back on each side in apposition with inf. turb. They came many times complaining of an irritated throat.

There was a type who had at times, what you might almost call "asthmatie attacks" and yet they were not truly asthmatic, as the attacks only came on whenever the patient had an acute cold.

There was a type that complained of headache. This would not necessarily mean a frontal headache. It could be any part of the head. There were many eye symptoms in this class, and the patient had been frequently refracted with no relief.

Then there was a type which, I believe, is one of the most important types. They eame com-

plaining of sinus involvements. This sinus type include the acute suppurative, and the chronic suppurative ethmoidal cases; the acute non-suppurative and the chronic non-suppurative ethmoidal cases. Those types of frontal sinus cases which are non-suppurative, where patient complains of pain in the floor of the frontal sinus, due to the constant tugging of the superior oblique on a thin bone, whose sinus side has an air cavity with the oxygen depleted, I only observed four of this sinus type where I could locate any sphenoid sinus involvement. The middle turbinate is often so flexible that the septum presses it outward, closing the natural oseous opening of all the important air chambers. I have operated cases following acute ethmoiditis and find the middle turbinate very thin and spongy, with but little more resistance than a piece of linen cloth.

I have in mind particularly one case, where for several years previous to my operation, the patient had had from three to five ethmoid attacks each year. This case I operated some three years ago, and was informed by her only a short time ago, that she has never had another attack of ethmoiditis since the operation.

I am discussing this particular type somewhat in length, because I am sure it has been a neglected type. There have been a great many sinus operations done where the septum should have been more carefully inspected and a radical resection of the septum done instead.

Just a word about the position of the patient at time of operation and the surgical field. Strict asepsis should be followed out in all nasal operations, but especially in septum operations. You are opening a route to the cribiform plate and you are separating perichondrium from cartilage and periosteum from bone. The cartilage and bone are removed and perichondrium is placed on perichondrium and periosteum on periosteum, closed up tightly, and by many of our rhinologists sewed up tightly, where drainage is poor, which enhances the possibility of infection.

In the early days of the sub-mucous operation, as I learned it from Hajek in 1904, the infections were tenfold to what they are now, with the entire field a field of rigid asepsis.

For several years I have operated all of my nasal cases in a recumbent position. The discomfort of the patient and the disadvantage of using an assistant led me to place the patient in a better surgical position. Those of you who are not operating in the recumbent position, will be greatly relieved by adopting a technique that permits it. I believe many have failed to use the recumbent position, because you really have to learn over the anatomical land marks in the nose. This, however, is easily done and you will find that there are many points of advantage both for yourself and the patient.

The ordinary surgical table is unhandy, it cannot be raised or lowered and the top of the table is so broad that you cannot get in a good operative position in front of the patient. Six years ago, I devised a table particularly for nasal operations that I have found saves me a lot of time and by curving in the top of the table five inches, puts me in better position in front of the patient for operating.

There have been many instruments devised especially for septum surgery. First, they were thick and very clumsy, then there was a special little instrument for every little turn in the septum, and then most every rhinologist in the country made some kind of a new instrument for septum surgery; now we have reached an age where most of us have cast out the goats and come down to about a standard set of instruments, which has really helped to standardize the operation, and I hope, will help to standardize the sub-mucous resection of the septum until we can speak of all sub-mucous resections as the *radical* operation.

DISCUSSION.

Dr. H. B. Hitz, Milwaukee: I want to compliment Dr. Dwight upon this paper. It brought to mind a little talk that he and I had about a year ago upon the same subject. We both were pretty well agreed at that time, and I see we are both pretty well agreed at the present time.

I believe that sub-mucous resection is one of the nicest operations ever devised for the correction of nasal disturbances. There isn't any question but that the drainage derived by the correction of defective septa is one of the most effective measures for preventing the recurrence of such conditions as Dr. Dwight has spoken of in the upper region of the nose. I have in mind a well known physician who had a very serious injury to his nose many years ago, and had been operated on three times before. I was asked to try my hand, always having as a result the old disturbance, which had never been corrected by any of the measures hitherto instituted, viz: recurrent attacks of acute sinusitis. Finally, upon a great deal of persuasion, he submitted to the sub-mucous operation. We did not get a perfect result.

We, however, got a perfect functional result. He said to me one day recently: "The only way to treat sinusitis is to remove the septum." Of course, that is not true, but that was his view.

Dr. Dwight's paper brought to my mind a scheme that I have followed for a great many years for the purpose of making people clearly understand the condition of the septum, and the need of its correction. Patients do not always appreciate the fact that there is a certain amount of difficulty in breathing because the septal deformity has been of slow development, as a rule—unless it results from injury. I speak principally of these cases that come from development—perhaps a green-stick fracture in youth. This leaves a certain degree of chronic obstruction of which they are to a large extent unconscious. They however, notice the difference after correction. The correction comes suddenly, and the condition having come slowly.

What I had in mind, when I got up, was to refer to a little scheme I have followed. It conveys, perhaps, in the best way that I know of, the idea of the relative capacity of the nose. If you look upon the nose as a cylinder, as a tube, divided in the middle by a central partition, you will appreciate that these tubes have a certain daily capacity. That is, they have a certain capacity for passing a stated volume of air, at a certain rate of speed, within a specified space of time. I have had patients, and even doctors, say to me: "Well, that doesn't need any change, because, while it is narrow on this side it is wider on the other side." That is not true. The capacity of a tube is *not* determined by its widest diameter, but by its narrowest. Therefore, if you bend the partition, and widen up one side of this tube at the point indicated (illustrating) you have not increased the capacity. You have, however, diminished it on the other side to the extent that you have deviated from the normal. Let us say it goes this way, in a crumple of the partition (indicating) which is due to an end-on blow. In the partition you will get an obstruction similar to that produced by a solid plug of cross diameter equivalent to the limit of deviation. Now, if you look upon it from the mechanical standpoint you get an idea of what the patient is suffering from. If you have a deviation way over here (indicating) the turbinal structures on this side (indicating) are coming in fairly close contact with that septum; and then because of all the work being done on one side, there develops a compensatory hypertrophy of the turbinal, further narrowing the nostril, so much so that you may have to remove part of it before you can get a perfect result. You have, therefore, had more than the loss I have spoken of: You have the additional loss due to compensatory hypertrophy.

Dr. Franz Pfister, Milwaukee: I am glad that the doctor spoke of the position of the patient. I have come to the conclusion that it is the proper position, and I have practiced that now for years. I give the patient a quarter of a grain of morphine half an hour before the operation. I place the patient on his back on the operating table, which puts him in a comfortable position and a comfortable frame of mind; he doesn't fret and do a lot of fussing, as they do when they are sitting in the chair in front of the operator.

After the initial preparation, the sterilization of the field around the nose, the next thing I do is to take a ten per cent solution of cocain and paint the nose. That gives me the field. I can see my work, and see what I have to do. I then follow that up with the injection of a one-half per cent solution of novocain, or a twentieth of one per cent of cocain, which is equally effective if novocain is not available and add one drop of adrenalin to the fluid dram of solution. I infiltrate on both sides. In that way I have no bleeding; no pain. It is perfectly easy to dissect the soft structures after the infiltration is done thoroughly.

I have adopted the septum splint of Dr. Todd of Minneapolis, which is a clamp and holds the septum after adjusting the edges perfectly. I leave it in place for forty-eight hours in packing. There is very little bleeding. If there should be any bleeding you can always stuff something inside for a few hours. You will have a patient who will tell you afterwards that he has not felt much if any pain.

I believe, like Dr. Dwight, that there are two points that must be taken care of: One is the anterior lower part of the septum and the other is the posterior higher part.

Dr. F. A. Davis, Madison: Recently I have been impressed with the importance of the diagnosis of the pathological deviation of the septum. According to Hirsch of Vienna, the deviated septum is physiological in white races, and it is certainly true that we see a slight deviation in the majority of patients who consult us.

Working upon this basis I have until recently avoided operation, unless the deviation seemed sufficiently well marked, or there were sysptoms of actual obstruction. This, however, I believe is a mistake. There are a large number of cases which, upon casual inspection of the nose, show but slight deviation, yet in my opinion these very cases are in more urgent need of operation than perhaps the case which shows a large prominent cartilagenous spur. I am referring particularly to the high deviation in the perpendicular plate of the ethmoid, which shows a gentle curve in the region of the middle turbinate, sometimes extending over and partially obscuring it; the lower part of the nose will be entirely free and the patient have no symptoms of nasal obstruction whatever, but he usually complains of headaches and occasional attacks of frontal sinusitis or ethmoid attacks. I have found on operation of a number of these cases marked changes in the middle turbinate. It usually extends further upward and backward than we can see. The turbinate is often atrophic, pressed firmly upon the lateral wall of the nose thus blocking the drainage from the important sinuses which open into the middle meatus, with its resultant train of symptoms, associated with such blockings.

One of the most important of these symptoms is the frontal sinus pain, which apparently is often due purely to an exhaustion of the air from the middle sinus, with the resulting pain which this brings on.

I am referring here largely to those cases which appear on the surface to have a very slight deviation in the upper nares. These deviations can be removed almost to the nasal bones with perfect safety as the cribiform plate, as a general rule, lies far above and behind them. I think it is also a good practice to fracture the middle turbinate from its attachment, thus opening up the middle meatus, and often it may prove best to remove a part of the middle turbinate.

There is another part of the deviated septum which I think is often overlooked, and that is the spur in the posterior end of the vomer ridge. While we may look into the nose and find the ridge not well marked, yet thorough cocainization will often reveal a marked deviation far back in the posterior margin of the septum, which often is so exaggerated that it presses against the turbinate or lateral wall of the nose in the region of the Eustachian tube. Here also mistakes in diagnosis are easily made, due to the fact that the anterior nares is often quite free and a probe easily passes into the post nasal space under this ridge. I have found this particular type of case associated with symptoms of tubal catarrh and the deviation undoubtedly causes congestion in this region with a consequent extension of the trouble into the Eustachian tube and middle ear.

Personally I am becoming more and more in favor of a thoroughly radical operation in these cases, and it has been forced upon me by patients coming again and again with symptoms unrelieved by refraction and treatment of the nasal pharynx. My results have been most gratifying in a number of such cases which I have recently operated.

Dr. W. W. Gillespie, Milwaukee: I am glad to hear so many good things said in connection with the submucous operation. I wish to offer a few remarks upon some phases of this operation for the purpose of emphasizing some of the many good things to which reference has been made by the speaker.

The discussion of the sub-mucous operation brings out the question of the best way to produce anaesthesia, and for what purpose the operation is performed.

The cartilaginous plate removal is simply a means to an end, the displacement of which simply opens an avenue for the removal of more important structures such as the plate of the ethmoid and crest of the vomer. The removal of the upper part of the ethmoidal plate upon which much emphasis has been placed during the discussion, is not of such great importance as the removal of the lower structures such as the lower part of the ethmoidal plate and the crest of the vomer. When you get down on the crest, the ridge which forms the upper part of the vomer, you come to a bony structure the removal of which is most imperative in order to overcome stensis and give the patient sufficient and free aeration through the nose.

When you get a patient into a chair, and upon examination find a condition of stenosis, which operation are you going to perform first, the turbinectomy or the sub-mucous operation? As a general procedure the latter should be performed first in all such cases.

In the performance of the sub-mucous operation, the speaker has emphasized too much the imporance of the removal of the cartilaginous septum and the upper part of the ethmoidal plate. This is the part which needs, practically, little attention. The great trouble in nearly all sub-mucous cases will be found in the angle of deflection or in the crest of the vomer, and unless you get this obstruction out, you practically accomplish nothing.

As to the methods or details in producing anesthesia little has been said other than the fact that a solution capable of producing anaesthesia is employed. As an initial procedure you can use a four or five per cent solution of cocaine upon both sides of the cartilaginous and bony septum of the nose, and reaching from the uppermost part to the floor of the nose. Then use adrenalin and the pure cocaine crystals. Make a little swab by rolling a small amount of cotton on a silver applicator, then moisten it in an adrenalin solution before dipping it in the cocaine crystals. Little discomfort follows the application of adrenalin and cocaine crystals, after you have first, as on initial procedure, used a four or five per cent cocaine solution upon the area to be involved in the operation. At the expiration of twenty minutes following two or three applications of adrenalin and cocaine crystals, you can start your operation. By this method you can get a better anaesthesia than is accomplished without adrenalin. The use of the latter will give you control of the absorption of cocaine into the system. A mere solution of cocaine without adrenalin is not to be recommended for the main anaesthesia.

Then as to the position of the patient, whether in the recumbent or in the erect position, is one of importance. Most all of our best operators in this country use the erect or sitting-up position. We assume the upright position for the reason that holding the head slightly forward and tilted downward during the anaesthesia, you confine the cocaine to the area to be operated upon, and at the same time prevent the cocaine from getting back into the pharynx where it can be spread over a large undesired area thus increasing the absorption and toxicity to the system. The convenience for the operator in this position is somewhat better, as for instance in the focusing of light, and the freedom and ease of movement for the operator.

As to the kind of incision—Hajeks', Kilian's, Freer's or some modification of the same that you may decide upon depends on the operator, and the nose to be operated upon. Some can use one method better than another. Choose the one you think best for that particular patient. Whatever you do, be sure you are working on a patient that has been properly anaesthesized before making an incision. After you have made the incision and elevated the mucoperichondrium and periasteum along the upper part of the cartilaginous and ethmoid plates, be sure and get down lower to the crest of the vomer—to an area that will give you much trouble if your patient is not properly anaesthesized. If you fail to remove this deviated vomer with its crest, you have failed in the operation, and practically accomplish nothing. Unless you get out the angle of deflec-

tion, and get what you went after, more harm than good is done.

Another subject to which reference has been made, is the treatment of the patient immediately following the operation. One of the first questions one might ask is: Are you going to pack one or both sides of the nose, or leave it open? The packing of both sides would depend upon the nature of the lacerations resulting from the operation together with the degree of hemorrhage. One can safely say that the packing of the one side upon which the incision has been made, will generally suffice. In packing the nose one of the speakers emphasized the importance of having a marked degree of pressure to keep the flaps in apposition. Very marked degree of pressure is unnecessary. We should employ just enough pressure to keep the flaps in apposition and to check hemorrhage. You put two incised or mutilated surfaces in apposition and employ undue pressure, you will find that it is not the way to hasten granulation and preserve a healthy or normal tissue. Faulty packing, or where the packing does not offer sufficient pressure, may result in the formation of a blood clot or hematoma. The latter usually occurs in cases of faulty packing, especially in those cases where there are projections from the turbinate, or where the latter is so large that you may overlook, or not be able to get the packing far enough back in the nose. The rule is that on removing the packing on the following day, you frequently have a haematoma resulting from this faulty and imperfect packing. In such cases re-packing is necessary.

As to the kind of material used in packing, it is best to use narrow strips of sterile gauze dressing, or the compressed cotton pledgets manufactured for that particular purpose. As to the choice between these two kinds, it is not important. I should not leave the packing in the nose more than twenty-four hours for the reason that the open nose is better to facilitate healing and to keep it dry. Do not keep up a constant application of medicine to that part of the nose operated upon, unless unusual conditions arise that make it necessary. The mere keeping of the packing there for a longer period, is a pathalogical question. Where the packing results in the formation of new foci of infection, you get increased pathological conditions, giving rise to increased suppuration. After the removal of the packing at the expiration of about twenty-four hours, my observation has been that the patients do better with the nose open,—and free from any form of packing. There are always some scabs or crusts in and about the healing area. In some cases there may be a slight amount of secretion and pain varying in duration from four to six weeks following the removal of the packing. Ordinarily in from ten to twelve days, you find but little trouble resulting from the operation.

Dr. W. E. Grove, Milwaukee: I would like to ask Dr. Dwight's opinion as to how he handles a case where there is subluxation of the cartilage. About a year ago I presented a paper in which I advocated attacking subluxations from the original septum incision, and not going through the skin anterior to the subluxation. I found that by making a Freer incision, fairly well forward, subluxation portion of cartilage could be peeled out with extreme ease, with a dissector slightly curved from behind; much easier than from an anterior incision through the skin over the front of the subluxation.

Dr. Bradfield, La Crosse: I do not use Dr. Dwight's table when doing a sub-mucous under local anesthesia, but use the regular chair, putting the patient in a reclining position as soon as any signs of circulatory disturbances appear, but always use the table when giving a general anesthesia, and am very thankful to Dr. Dwight for his invention.

If three special conditions of the septum are remembered it will greatly aid us in the sub-mucous work. The deflection may be in the anterior portion of the septum almost or entirely closing one nostril, leaving the other side quite free, when there is always a ridge at the lower part of the septum, which if not thoroughly removed will leave but poor results on the stenosed side.

In the second variety there is a deflection high up and well back, which presses into the turbinal region on the side obstructing breathing.

In the third there is a double "S" deflection, which apparently interferes but little with nasal breathing, but almost or entirely blocks the middle and superior meatii on one side, causing blocking of the natural drainage of the sphenoidal, ethmoidal and frontal sinuses on that side.

In the first variety the removal of the deflected portion of the septum with the deviating ridge is all that is necessary, but a failure to properly remove this ridge leaves a very defective operation.

In the second variety all the deflection and the thick portion of the septum should be thoroughly removed; in the third variety removal of the deflected portion of the septum extending to the very top is absolutely necessary to give proper drainage. The radical operation when properly done is one of the finest and most useful operations ever devised by a surgeon and is invaluable in chronic sinusitis and otitis media.

Dr. Charles J. Coffey, Milwaukee: I would like to call attention to a phase of this question which has not been touched upon, either in the original paper or in the discussions thus far, viz.: the part played by secondary hypertrophy of the turbinal structures in producing nasal obstruction in these patients with deflected septums. While as shown by Dr. Hitz's illustration, the respiratory capacity of the nose with a deflected septum is materially lessened; patients with considerable deformity of nasal septum can, and for years frequently do, get on without much difficulty if secondary hypertrophy of the turbinal bodies is escaped. The hypertrophy is an indirect result of the deflection itself. Owing to the mechanical interference with ventilation and drainage, infection of nasal mucous membrane is favored, and frequent attacks of acute rhinitis and sinusitis results with chonic hypertrophy of the turbinates. Ballinger, however, lays particular stress on the etiological part born by changes in the air pressure within the nasopharynx and the nose, caused by the presence of a

deflected septum. In the act of inspiration the chest capacity is increased and if air does not rush in at a rate and in sufficient volume to satisfy the increased capacity, a negative pressure is produced in the nose with the effect of a cupping action on the vascular turbinal bodies. This passive congestion continued over a long period of time aided at intervals by infection, produces a hypertrophy of the turbinals which in many cases is more obstructive than the original deformity itself. I believe it is highly desirable to have a clear understanding on this point in order that we may understand why it is that symptoms of obstruction often times come on years after injury or completion of development of the nose, and be able to explain to our patients that seemingly inexplainable aspect of the case. A clear conception of the pathological changes in the turbinal bodies which results from deflection of nasal septum, will be of great aid in determining when and to what extent we should interfere surgically in this form of nasal obstruction. I believe that the correction of comparatively slight deflections where there is a positive tendency to turbinal hypertrophy which cannot be explained on any other basis, will often time save the patient from annoying nasal obstruction and obviate the necessity of sacrificing valuable turbinal tissue later on.

Dr. C. W. Wilkowske, Chippewa Falls: I want to thank Dr. Dwight for calling our attention to the fact of these high deviations of the septum. In the discussion we seem to forget the real function of the nose. The nose is not simply to get air, but to get air in the proper way. The function is to warm and moisten that air by the time it reaches the pharynx. Many of these nose patients come in and complain of mucous dropping into the throat, and pain in the frontal sinuses. They say they have plenty of space for breathing, and demonstrate it, but the current of air does not come in the proper way. The current should go upwards and backward. It should circle through these fossa. That is where our high deflections come in.

We also get conditions where there is not a real deflection, but a great thickening of the triangular cartilage at the point of union with the perpendicular part of the ethmoid. In those cases that part should be removed. I have seen cases where the cartilage was three-eighths of an inch thick. You can readily see how much more of a proper breathing space you would get by the removal of this part of the septum.

Dr. H. B. Hitz, Milwaukee: May I ask one question of Dr. Dwight? Has he had any experience, or been able to attribute these air-pressure pains in the frontal sinuses to barometric causes?

Dr. C. W. Wilkowske, Chippewa Falls: I would ask if the doctor has observed any increase in weight in his patients following this resection? I had one case where the lady increased twenty pounds; and this summer I had one young man who, two months after the operation, had gained fifteen pounds.

Dr. C. G. Dwight, Madison: Answering Dr. Hitz, I think this subject was discussed thoroughly by Slüder in an article read at the time he was admitted into the Laryngelical Society of Chicago. It is true that weather conditions influence these cases. When the osseous opening is closed the air is cut off, the oxygen is depleted. Slüder went so far as to say this formed a negative pressure. I do not know that there is any way to determine whether there is negative pressure. He said a vacuum was formed there by the depletion. I do think there is negative pressure which you are unable to meet, and that the weather has a great deal to do with it.

That very same thing is true with reference to what Dr. Coffey has just said as to the condition of the turbinates. The condition of the turbinates is influenced very largely, I think by experience, in the pressure of the deviated septum upon the turbinate body; it may be the superior, it may be the middle, or the inferior turbinate.

On the removal I make it a rule not to combine operations. I do not remove turbinates at the time of sub-mucous operations, for the reason that I believe that ninety-five per cent of your cases of turbinal trouble will correct themselves, if you correct your septum, and give the middle turbinate a chance to recover, and in a very large per cent of the cases it will do it.

I have been doing, within the last three years, the sub-mucous resection of the inferior turbinate on the line which Dr. Coffey speaks of. You will find it a great relief, rather than to remove the mucous membrane which was placed there for a very decided purpose. It is the membrane that secrets and produces the moisture in the nose.

I am not talking to the general surgeon today, but the sub-mucous resection is an operation that the general surgeon has religiously left alone, because it is an anatomy that he has not studied to any great extent. However, there are some of them that are removing spurs, and doing little operations for deviations, either in the lower or central portion of the nose.

Dr. Pfister spoke of the preliminary anesthesia. The anesthesia by placing your patient on his back is very easily accomplished. Your swabs, of course, should be pressed dry, if you use them, to prevent the unnecessary cocain solution running down the throat. It should not be done with a sloppy wet swab or sponge. Those cases, in my own particular practice, are turned over to the nurse, who does the preliminary anesthesia. It is a simple thing to anesthetize the nose. But it is an important thing. The lower part of the nose should be taken, rigidly, into consideration; the floor of the nose, along the vomer ridge. You must, in all cases, anesthetize. It is extremely important. It is just as important to anesthetize the upper part of the nose. I have not written this paper entirely upon the upper area of the nose, but I made this statement: That a radical operation means removing all of the deformity of the septum in apposition with the outer wall, giving a free and normal breathing space. I would consider an operation on the septum absolutely incomplete if leaving any one of the parts, above or below. You will go into a nose and find the lower part of the nose the only part that has to be operated on. I am only speaking of the upper portion because it has been overlooked. I am sure there are certain surgeons in this room that have overlooked

it, and I am simply saying to you that if you will observe it you will find a decided relief in a great many of your cases. It is just as important that that part of your septum which is in apposition with the middle turbinate be looked at as other parts of the septum, or in the region of the vomer, or the triangular cartilage that is in apposition with the inferior turbinate. It is not a septum operation if you leave it like that. It is simply going in and removing part, and not making a radical operation. That is the reason for my plea.

This is a very long subject and I did not go into the technique very thoroughly, because people don't like a long paper.

I believe in the hands of a trained nurse the anesthesia can be prepared in twenty or thirty minutes. If your nurse knows your technique she can prepare those things for you, and she can prepare it easier in the recumbent position than in the sitting position.

What you use for anesthesia depends on the patient. I think there are very few of us who do not use the flake cocain, where we dip a sponge into the adrenalin solution, 1 to 1000, and then go over the area.

The point Dr. Pfister brought out in regard to injecting the septum with adrenalin, and novocain solution: The amount of adrenalin used is unimportant. The amount of novocain we are using is not important. I used to use one drop, 1 to 1000 adrenalin, in one dram normal salt solution, injecting anterior and back through the cartilaginous portion of the nose, which simplifies the amount of hemorrhage you have. It is a practically bloodless operation.

Answering Dr. Gillespie's view: I want to make that plain, that the inferior part of the nose is just as important as the upper part of the nose. This posterior region in here, that you have all come in contact with, may be the only marked deformity you have. You have thickened septum, and you go back onto this thickened septum, and you will find this condition in apposition. It may be one side or the other, or may be both. The little diagram Dr. Hitz made for us is very important. I believe every rhinologist should have in his office some mechanical means by which he may explain to the critical person why he is doing that. I hope someone will make such a toy. It is a difficult thing to explain to the layman. Some people demand an explanation. I avoid it every time I can.

You may have this deformity (illustrating), and if you have not gone into this with the idea of making a radical operation you are going to leave the very thing that should be attended to. In this particular case I would use the Yankaur incision, far back, and then I would not have to destroy but very little of the perpendicular plate. It is important not to destroy more tissue than necessary.

In answer to Dr. Gillespie: You will find this septum deviates in this manner (indicating). You have to remove this part here (indicating). But when you come to leave the upper air passage, which is the normal passage to ventilate that particular region, if you do not remove this part in here (indicating), so that your flap will hang straight down, you have not served the patient in this operation. I do not care what part of the septum is involved, you are to remove it or you have not done to your patient what you want to.

Mr. Davis thought he would embarrass me by saying that I had the pleasure of operating on his nose. I am sure Dr. Davis had been in the hands of very good rhinologists of very much greater reputation than I have; at the same time I did a radical operation and relieved him from symptoms of high-up curvature which he had never been relieved of. The lower portion of his nose was as free as any average nose, in normal condition, and it was not necessary to operate on that part of the nose. It was necessary to operate on that part of the nose which was serving the air passages high up.

With regard to the incision for the anterior deflection, I want to compliment Dr. Grove by telling him that I went home and tried his operation, and I believe he has suggested one of the cleverest methods of incision we have had on the strictly anterior deviation. I am using Dr. Grove's method, and it is very helpful to start in at the very anterior part of a septum and dissect back. Sometimes your lateral cartilages will not entirely support your nose, but you are satisfied with a slight dropping of the end of the nose. I consider it a very excellent addition to the sub-mucuous operation where you have difficulty with the anterior part of the septum.

I think I have covered everything, but I would be very glad to substantiate my statements with reference to the middle part of the nose, where the middle turbinate is involved, not making this anything but one of the classifications.

SEMINAL VESICLEOGRAPHY.

BY HENRY J. MILLSTONE, M. D.,

UROLOGIST TO WASHINGTON PARK HOSPITAL.

We are indebted to Belfield for the first X-ray picture of the Seminal Vesicles. Although a relatively simple procedure still it has not been given the popularity it justly deserves, for it certainly has a definite field of usefulness.

Much can be learned from rectal palpation of these structures and should be employed routinely, however one cannot always successfully examine the Vesicles satisfactorily for obvious reasons, such as a short finger, a very highly neurotic and sensitive patient, etc. In many cases the most distal portion of the Vesicles, the Ampulla, is the seat of pathology and rarely is it possible to palpate them. A Vesicleogram gives us more detailed information as to the capacity and internal conformation. It is also possible to detect foreign bodies, kinks and strictures of the Vesicles. Oftimes in cases of Sterility where it is not possible to find the spermatzoa, the trouble may not be the ab-

scence of the spermatazoa, as an obliteration of the ejaculatory ducts with the inability of the spermatazoa to "get out" literally a "bottling up" of the products of conception. This phenomena can be most excellently demonstrated in the Vesicleogram. With a Vesicleogram it is very simple to differentiate between a foreign body in the vesicle, ureteral stone and calcified Iliac lymph gland.

Below is an unusual X-ray picture of the Vesicles inasmuch as it so clearly shows the ejaculatory ducts, the Vas deferens and the tortuosity of the Ampulla of the Vas and Vesicles.

1) Vas Deferens in Inquinal Canal.
2) Beginning tortuosity of the Vas.
3) Ampulla of the Seminal Vesicle.
4) Ampulla of the Vas.
5) Left Seminal Vesicle.
6) Ejaculatory Duct.
7) Veramontanum.
8) Glass tube in rectum for air inflation.

The objection raised by most men is the possibility of sterilizing the patient. In a letter from the originator of the operation and from the experience I have had with Dr. Herbst who has reoperated many patients, in no case has the Vas been obliterated. In seventy of my own cases in which I reoperated five, in no case was the Vas obliterated.

We must admit however that the possibilities of sterilizing the patient are present, but if we will be cautious about those factors that pave the way for adhesions such as infection, trauma, hemorrhage, etc., the danger is nil.

The blood supply around the Vas is splendid so that recovery from surgical trauma is rapid and sutures, hemorrhage, etc., are readily absorbed.

I do not wish to encourage the routine employment of this procedure nor should it be used promiscuously, however it has its definite indications and field of usefulness in properly selected cases and certainly should be given its just recognition in the diagnostic sphere of these structures.

TECHNIQUE.

The patient is given a brisk cathartic the night before and an enema the morning following. After trying many substances I find Collargol in 10 per cent strength the best. It not only throws a good shadow but it is a splendid germicide and can be well recommended as a therapeutic agent in all types of vesicular infections, excepting tuberculosis.

The anterior scrotal region is shaved and prepared, and the usual surgical precautions strictly observed.

From now on one pursues the same course as in a Vasostomy. After opening Vas the Vas deferens needle is introduced and the Collargol which has previously been warmed is slowly injected. If the Collargol is injected too rapidly instead of filling up the vesicles the Collargol will be "squirted" out into the urethra. The Collargol is injected until the patient complains of colicy pains in the base of the bladder. This will vary from 10 to 30 c.c. depending on the pathology present.

The rectum and the bladder are both inflated with air. Dr. Lyons* has found by applying pressure over the supra pubic region the picture will stand out better. This can be accomplished by placing an ordinary abdominal binder around the abdomen and drawing it snug.

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*I wish to thank Dr. Lyons, Roentgenologist to Washington Park Hospital for his many useful suggestions and kind co-operation in this work.

(1) Belfield, W. T., S. G. O., Nov., 1906.
Idem., J. A. M. A., Dec. 25th, '09.
Idem., J. A. M. A., Nov. 22, '13.
Herbst, J. A. M. A, Dec. 21, '12.
Thomas, Am. Urological Assn., April 19, '16.

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ROCK SLEYSTER, M. D., Editor
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J. P. McMAHON, M. D., Managing Editor
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EDITORIALS

OCTOBER MEETING STATE MEDICAL SOCIETY.

THE annual meeting of the State Medical Society of Wisconsin will be held in the Auditorium, Milwaukee, October 2d, 3d and 4th. During these strenuous times when so much is expected of our profession—more than of any other body of men, it becomes the duty of every physician to support in every possible way the organization which is required to assume responsibilities never asked of it before. Not the least among these duties is attendance at the annual meeting. It is especially important that members elected to represent their county societies be present at the opening session of the House of Delegates to be held at the Hotel Wisconsin, Monday evening, October first.

GROUP "B"—CLASS I.

MANY physicians unable to enter the Government service have asked to do their bit at home in any possible way. An opportunity to render a splendid patriotic service is now offered these men in helping to make ready registrants who have been placed in Group B, Class I. Under the selective service regulations these are the registrants with remediable defects. Many of these young men are anxious to join the colors and only await an opportunity to have disqualifying physical defects corrected. The Governor of Wisconsin has issued an appeal to those patriotic medical men who are unable to enlist in the Reserve Corps but who are anxious to co-operate in the big problem of placing an army of five million men in France to fight our battles for us. He has asked that they offer their services in correcting the physical defects of these men placed in Group B. He has also appealed to the County Councils of Defense to provide ways and means of furnishing free hospital beds. We assure the Governor and the War Department that the medical profession of Wisconsin at home stands ready to do its part as well as those of us who are doing their bit in uniform.

¶ Shirkers Get Paid What They are Worth

—Elbert Hubbard.

THE MEDICAL PROFESSION AND THE WAR.

MORE than 25,000 physicians have accepted commissions in the Medical Department of the Army, and at least 2,000 more are in process of being commissioned. Adding to this number those in the Navy, we can estimate that over 29,000 physicians have volunteered and are now either in active service or subject to immediate orders. The 5,000 asked for last May have

been supplied; another 5,000 will be called for immediately, and probably still another 5,000 later on. It is now generally believed that the present plan is to raise an army of 5,000,000 men as soon as possible. This means at least 35,000, if not 40,000 medical officers. The way in which our profession has already responded to the call of the Surgeon-General demonstrates both the patriotism and the proverbial unselfishness of the average medical man. No doubt the same spirit would supply the 40,000. But this voluntary method of furnishing the Army with medical officers is as unfair and as unsatisfactory as would be the same method of supplying the necessary personnel for the fighting force.

* * *

The physician who is prompted by a purely altruistic spirit, the one who is always willing to make sacrifices for his country, the one who is willing to give up a position attained through years of endeavor for the good of the common cause—these are the men who have been coming forward from the first, and who will continue to come forward. The man who wants to utilize the opportunity to make money, the man who would capitalize the sacrifices of a confrère, the indolent—these find it possible to explain—to themselves—why they do not volunteer. There are, of course, those whom the Surgeon-General's Office will not commission because it knows of justifiable exempting circumstances. There are those whose entrance into the service would be a distinct loss to their communities and, in the final analysis, to the government. It is hoped that some of the plans advanced will give us our medical officers, taking each man as his turn comes after consideration of his domestic responsibilities and his community need.

It may be proved with much certainty, that God intends no man to live in this world without working; but it seems no less evident that He intends every man to be happy in his work. It was written: "In the sweat of thy brow," but it was never written: "In the breaking of thy heart."

—Ruskin.

THE PART THAT CIVILIANS PLAY IN THE WAR.

SEPARATED by 3,000 miles of ocean and protected by our Navy, our civilian population can during this war continue to live in the same security as in peace times. The Hun invaders are not in our midst. We are spared the agony that came to the women and children and old men of Belgium and France and Serbia and the other over-run countries. While thus secure from harm we must not forget that the civilian populations of these desolated countries are as much our allies as are their fighting men. Let us realize more deeply their tragedies.

Read this testimony of Brand Whitlock, who, as our minister to Belgium, knows what it means for a land to be occupied by German troops:

"Tamines is a little mining town on the Sambre. The little church stands on the village green overlooking the river, its façade all splotched where the bullets and grapeshot spattered against it. And in the little graveyard beside the church there are hundreds of new-made graves, long rows of them, each with its small wooden cross and its bit of flowers. The crosses stand in serried rows, so closely that they make a very thicket, with scarcely room to walk between them. They were all new, of painted wood, alike except for the names and the ages—thirteen to eighty-four. But they all bore the same sinister date—August 22, 1914.

"The Germans began to pillage and burn the houses, 676 of them; then they turned all the inhabitants into the street, promiscuously marching them about. It went on for long hours; they were given no food or drink. During a halt they forced them to lie beneath the machine guns, then they lined them up against the church wall and performed a mock execution. About 600 men were massed in St. Martin's Square, on the river bank, and their wives, mothers, daughters were assembled by the soldiers to witness the scene.

"They lined up their victims in three rows along the Sambre and tumbled 150 of them head over heels into the river, shoving back with their bayonets those who attempted to cling to the bank. Only four or five escaped by swimming. During this first execution the machine guns were trained on the remaining lines. When the firing had ceased that night, there were more than 400 dead; their bodies lying there, women, too, and children.

And the graves are there near by, in the cemetery, and the ages given are from 13 to 84."

The part that these civilians played in the war was to bring to the civilized world the realization of what it would mean for German arms to conquer. In playing their part they gave their lives in the most cruel way a beastly enemy could devise.

What part will our civilian population play in the war? Will it go along living as it did before the war, or will it glory in the opportunity to serve in the tremendous task of defeating civilization's enemy? Each individual must decide that question. He can prolong the world's agony or he can save—save and sacrifice—to the utmost of his ability and with his savings buy War Savings Stamps that there may be more money, labor, and materials to back up those who fight and die not only for us, but for all who love freedom.

CUT DOWN ON EXPENSE: LIVE THE SIMPLE LIFE.

HERE are a few points on thrift given by the British Chancellor of the Exchequer which are worthy of emulation by Americans:

Lives must be lived more simply.

Personal, household and business expenses must be reduced to the minimum.

Surplus weekly or monthly earnings, over necessary expenditures, must be invested straightway in war securities.

Current balances at the banks should be kept as small as possible and the money invested in war bonds.

Nobody's money can be neutral.

Money lent to the country fights for the country.

Money spent on luxuries and non-essentials is helping the enemy.

CALL TO DUTY.

FROM the battle fields in France there comes an unspoken call that should find an answer in every American's heart. The recent great events in Europe, the successes of American arms on the fields of France should spur every American to greater effort.

Our people at home should not rest on the laurels of our soldiers in France. Every death on the field of honor in the line of duty and for our country's cause should be a call to us for every sacrifice and every exertion to aid the cause for which our soldiers are fighting, for which our soldiers have died.

Increase production, decrease consumption, save, and lend to the Government. Every cent lent to the United States is used to support, strengthen, and aid our soldiers in France.

MEDICAL MOBILIZATION AND THE WAR

VOLUNTEER MEDICAL SERVICE CORPS.

The Volunteer Medical Service Corps was authorized by the Council of National Defense on January 31, 1918. Under this authorization the membership of the corps consisted of all physicians who because of overage, physical disability, dependents and essential home needs were not eligible for service in the Medical Reserve Corps of the Army or Navy.

On August 5th the Council of National Defense authorized a change in the scope of the organization and an increase and amplification of its Central Governing Board. Membership in the Corps as now authorized, makes eligible to the Corps every legally qualified physician, including women physicians, holding the degree of Doctor of Medicine from a legally chartered medical school, without reference to age or physical disability, provided he or she is not already commissioned in the Government Service. This organization has now the approval of the President.

The Volunteer Medical Service Corps is exactly what its name indicates. It is a gentleman's agreement on the part of the civilian doctors in the United States who have not yet been honored by commissions in the Army and Navy, and a representative board of governors consisting of officials of the Government associated with lay members of the profession, in which the civilian physician agrees to offer his services to the Government if required and asked to so do by the Governing Board.

It is a method of recording all physicians who are not yet in service and classifying them so that their services when required will be utilized in a manner to inflict as little hardship on the individual as possible. It is a method by which every physician not in uniform will be entitled to wear an insignia which will indicate his willingness to serve his Government.

As more than sixty per cent of the physicians of the country will be utilized in caring for the industries at home and the health of the home people, this large percentage of necessity will be expected to maintain their

home status and continue their ordinary professional work.

Many thousands of blanks for enrollment of the legally qualified men and women physicians of the country in the reorganized Volunteer Medical Service Corps are being mailed by the Chairman of the General Medical Board of the Council of National Defense. With the blank are enclosed a letter and a folder giving all details as to the organization.

The blank which applicants are asked to fill out reads:

APPLICATION FOR MEMBERSHIP IN THE VOLUNTEER MEDICAL SERVICE CORPS.

Authorized by Council of National Defense, Approved by the President of the United States.

(Spaces for date, full name, street, city and state addresses.)

1. Date of birth.
2. Place of birth.
3. If foreign born, when did you become a resident of the United States?
4. When and where naturalized? How?
5. Are you single, married, widowed, or divorced? Nationality? Color? Height? Weight?
6. State high school, academy, college, or university you have attended, with dates of attendance, graduation, and degrees received.
7. Give all literary or scientific degrees you have received and names of institutions granting them, with dates.
8. With what languages or branches of science are you familiar?
9. When and where graduated in medicine?
10. When and where licensed to practice medicine?
11. Name principal medical societies of which you are a member. (Do not abbreviate.)
12. What specialty of medicine do you practice?
13. Proportion of time devoted to specialty?
14. Clinical experience in specialty? Institution? No. of years.
15. State all past hospital services. Hospital. Capacity. Date.
16. Present hospital connections. Hospital. Department. Capacity.
17. School and teaching positions occupied in the past. School. Capacity. Date.
18. School and teaching positions now occupied. School. Department. Capacity.
19. State all past experience in industrial or railroad medicine and surgery. *Name and address of plant. Type of service* (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) *Duration of service.*
20. State all present connection with industries or railroads. *Name and address of plant. Type of service* (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) *Time devoted to each plant.*
21. State military, naval or public health experience you have had.
22. Are you a Federal, State, County, or Municipal officer? (State exact designation of your office.)
23. Are you engaged in enterprises other than medicine? If so, what?
24. Have you followed any occupation, medical or otherwise, not already noted?
25. Have you previously been an applicant for entry into the United States Service? Service. When. Where. Result. (If rejected, state why.)
26. I have not applied for appointment in the Medical Reserve Corps of the Army, the Naval Reserve Force, or the Public Health Service owing to—(Check reason).
    a. Physical disability. (State disability in detail.)
    b. Over age (55). (State age in years.)
    c. Essential institutional need. Name of institution. Position. Name and address of chief executive.
    d. Essential community need. Approximate population. Number of physicians now practicing in your community.
    e. Essential to Health Department. Name of department. Position. Name and address of chief of department.
    f. Essential to industries. Name of plant. Position. Name and address of chief executive.
    g. Essential to medical school. Name of medical school. Position. Name and address of dean.
    h. Essential to Local or Medical Advisory Boards. Name and address of Board. Position.
    i. Dependents. Number of dependents, including self but not employees. What proportion of your income or that of your dependents is derived from sources other than the practice of your profession? Do other persons contribute to the support of your dependents? Have you or your dependents other immediate relatives who could provide support for your dependents?
    j. Sex. (State your sex.)
    k. Religious conviction, not a citizen, or other reasons. (State reason.)
27. Are you available for any of the following services:
    a. Consultant. Medical Service. Surgical Service. Public Health Service. Special Service—What?
    b. Institutional. Laboratory. Administrative. Medical Service. Surgical Service. Special Service—What?
    c. Medical service for industries. Part time. Full time. Own community. Other communities. Kind of work.
    d. Local or Medical Advisory Boards.
    e. Reclamation of registrants rejected for physical unfitness.
    f. Services to needy families and dependents of enlisted men.
    g. Sanitation.
    h. Miscellaneous service.
28. Check the Governmental service in which you would prefer to serve, if selected.
    a. Medical Reserve Corps of the Army.
    b. Naval Reserve Force.
    c. Public Health Service.

NOTE—Wherever practicable, your preference will be given consideration. However, the exigencies of war may render it necessary to ask you to do service other than that indicated as your choice.

29. Personal references. (Name three, at least one physician.)

I hereby make application for membership in the Volunteer Medical Service Corps of the United States. I certify that to the best of my knowledge and belief, the answers to the preceding questions are true and correct in every respect. I pledge myself to abide by the rules and regulations of the Corps; to apply for a commission in the Medical Reserve Corps of the Army, the Naval Reserve Force, or for appointment in the Public Health Service when called upon to do so by the Central Governing Board; and to comply with any request for service made by the Central Governing Board.

(Signature) .....

(Present post-office address) .....

An outline of the purpose and scope of the Volunteer Medical Service Corps, contained in the folder, is as follows:

Volunteer Medical Service Corps organization:

1. Provides means for obtaining quickly men and women for any service required.

2. Furnishes recommendation and necessary credentials to assure the best of Medical service both military and civil.

3. Determines beyond question the attitude of the individual toward the war.

OBJECT OF CORPS.

1. Placing on record all medical men and women in the United States.

2. Aiding Army, Navy, and Public Health Service in supplying war medical needs.

3. Providing the best civilian medical service possible.

4. Giving recognition to all who record themselves in Army, Navy, Public Health activities, or civilian service.

WORKING PLANS.

All matters pertaining to the organization will be under the direction of a Central Governing Board, authorized by the Council of National Defense and approved by the President of the United States, and its affairs will be conducted from the general headquarters of the Volunteer Medical Service Corps at Washington, D. C., under the Council of National Defense.

OPERATING SYSTEM.

1. Central Governing Board of 25.
2. Forty-nine State executive committees.
3. One representative in each county in every State.

NOTE—(a) All men to be appointed to State and county committees preferably over 55.

(b) Each State executive committee to consist of five in the smaller States and one additional member in each of the larger States in proportion to each 1,000 medical inhabitants (to be nominated by State committees, Medical Section, Council of National Defense, from among their own members).

(c) Each county of 50,000 population or under should have one representative. All counties having over 50,000 population should have one additional county representative for each 50,000 population or fraction thereof. All county representatives to be nominated by the State executive committee.

DUTIES.

Central Governing Board—To receive and pass upon all appointments.

State Governing Boards—To receive facts from county representatives and make recommendations to Central Governing Board.

County Representatives—To submit facts to State committees according to advice from Central Governing Board or State Executive committees.

Under the reorganization, every legally qualified physician, man or woman, holding the degree of Doctor of Medicine from a legally chartered medical school, who is not now attached to the government service, and without reference to age or physical disability, may apply for membership and be admitted if qualified; whereas, the original organization admitted only those who for various reasons were ineligible to membership in the Medical Reserve Corps. The organization will mobilize the medical profession in order to provide for the health needs of the military forces and the civil population, and the recording and classifying of doctors will afford means of obtaining quickly men and women for any service required.

To date about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in government service or have volunteered their services. Up to July 12 the Surgeon General had recommended to the Adjutant General 26,733 doctors for commissions in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes 26.73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty.

The need of using wisely the service of the medical men, in view of the universal war activities, is indicated when it is known that in the five weeks ended August 2, there were 2,700 medical officers commissioned in the Army, Navy, and Public Health Service—or at the rate of 540 per week. This rate at which enrollment is proceeding is the cumulative result of the operation of all the machinery which has been in process of setting up since the United States entered the world war. While

the number commissioned in the five weeks mentioned may seem large, it is not much greater than the rate at which medical men have been receiving their commissions during the past year. There are now 28,674 medical officers commissioned in the three services—26,027 in the Army, 2,427 in the Navy, and 220 with the commission of Assistant Surgeon in the United States Public Health Service. Of the 2,700 commissioned in the five weeks ended August 2, there were 2,527 in the Army, 169 in the Navy, and 4 in the United States Public Health Service. Also, 40 doctors designated as Acting Assistant Surgeons have been taken on in the Public Health Service in the last two months, 21 for work in extra-cantonment zones, 14 for special venereal disease work, and 5 for marine hospitals. The 26,027 in the Army medical service comprise 933 in the Medical Corps, the regular Army service; 23,531 in the Medical Reserve Corps; 1,194 in the Medical Corps of the National Guard, and 369 in the Medical Corps of the National Army.

It is estimated that at least 50,000 doctors will be necessary eventually for the Army. It can readily be seen that with the enrollment of these active men, their places in communities and institutions must be cared for and the work, therefore, throughout the country must be so systematized and co-ordinated that the civilian population may not suffer. An important aspect is the need for medical men in the communities where munitions and other vital war products are being made.

The Volunteer Medical Service Corps, supervised by the Central Governing Board now named, will thoroughly care for these needs.

In connection with the mailing of membership blanks for the Volunteer Medical Service Corps to all legally qualified men and women doctors of the country, Dr. Franklin Martin, Chairman of the General Medical Board of the Council of National Defense, says:

"Great as has been the response to the appeal for doctors, it must be greater. It is imperative that every doctor not already in a government service fill out, sign and return the blank to the offices of the Central Governing Board, Council of National Defense, Washington, at once. We believe thousands will do this, as they are anxious to be enrolled as volunteers for the Medical Departments of the Army and Navy before registration under the new draft law goes into effect. The appeal for enrollment in the Volunteer Medical Service Corps, which President Wilson has formally approved, is an official governmental call to service. This will place the members of the medical profession of the United States on record as volunteers, available for classification and ready for service when the call comes."

PHYSICIANS MAY ENLIST.

On August 8th the following statement was authorized by the War Department, signed by Newton D. Baker, Secretary of War:

"The War Department today has suspended further volunteering and receipt of candidates for officers' training camps from civil life. This suspension will remain in force until the legislation now pending before the Congress with regard to draft ages is disposed of and suitable regulations drawn up to cover the operation of the selective system under the new law. * * ."

Fearing that this order might be misinterpreted by doctors who would not distinguish between enlistment as a private soldier and enrollment as an officer in the Medical Reserve Corps, the Secretary of War issued a statement making clear this point.

"Orders issued by the War and Navy Departments on August 8th suspending further volunteering and the receipt of candidates for officers' training camps from the selective system under the new law * * * ."
civil life do not apply to the enrollment of physicians in the Medical Reserve Corps of the Army and the Reserve Force of the Navy. It is the desire of both departments that the enrollment of physicians should continue as actively as before so that the needs of both services may be effectively met.

(Signed) JOSEPHUS DANIELS,
Secretary of the Navy.

(Signed) NEWTON D. BAKER,
Secretary of War.

THE OWEN-DYER BILL.

The bill in reference to the Medical Department of the Army as passed and approved by the President of the United States on July 9th, 1918, is as follows:

"Increase in Medical Department: That the Medical Department of the Regular Army be, and is hereby, increased by one Assistant Surgeon General, for service abroad during the present war, who shall have the rank of major general, and two Assistant Surgeon Generals, who shall have the rank of brigadier general, all of whom shall be appointed from the Medical Corps of the Regular Army.

That the President may nominate and appoint in the Medical Department of the National Army, by and with the advice and consent of the Senate, from the Medical Reserve Corps of the Regular Army not to exceed two major generals and four brigadier generals.

That the commissioned officers of the Medical Corps of the Regular Army, none of whom shall have rank above that of colonel, shall be proportionately distributed in the several grades as now provided by law.

That the commissioned officers of the Medical Reserve Corps of the Regular Army, none of whom shall rank above that of colonel, shall be proportionately distributed in the several grades as now provided by law for the Medical Corps of the Regular Army: Provided, that nothing in this Act shall be held or construed so as to discharge any officer of the Regular Army or deprive him of a commission which he now holds therein."

Under this bill the ranks in the Medical Reserve Corps, based on the report of the Surgeon General of July 12th, as as follows:

Major Generals	2
Brigadier Generals	4
Colonels	675
Lieutenant Colonels	1158
Majors	5063
Captains and Lieutenants	14374

TO PHYSICIANS OF AMERICA.

Surgeon General Gorgas has called for 1,000 graduate nurses a week—8,000 by October 1.

25,000 graduate nurses must be in war service by January —in the Army Nurse Corps, in the Navy Nurse Corps, in the U. S. Public Health Service in Red Cross war nursing.

This involves withdrawal of many nurses from civilian practice and necessitates strict economy in the use of all who remain in the communities.

You can help get these nurses for our sick and wounded men by—

Bringing this need to the attention of nurses.

Relieving nurses where possible wholly or in part from office duty.

Seeing to it that nurses are employed only in cases requiring skilled attendance.

Insisting that nurses be released as soon as need for their professional service is ended.

Seeing that your patients use hospitals instead of monopolizing the entire time of a single nurse.

Encouraging people to employ public health nurses.

Instructing women in the care of the sick.

Inducing high school and college graduates to enter the Army School of Nursing or some other recognized training school for nurses.

Encouraging nurses to go to the front involves real personal sacrifice and added work on the part of the physicians whose duty it is to maintain the health of our civilian second line defense.

But the men who are fighting for their country in France need the nurses.

Department of Nursing,
American Red Cross,
Washington, D. C.

THE UNITED STATES ARMY.

Washington, August 7, 1918.
War Department,

General Orders, No. 73.

1. This country has but one army—The United States Army. It includes all the land forces in the service of the United States. Those forces, however raised, lose their identity in that of The United States Army. Distinctive appellations, such as the Regular Army, Reserve Corps, National Guard, and National Army, heretofore employed in administration and command, will be discontinued, and the single term, The United States Army, will be exclusively used.

2. Orders having reference to the United States Army as divided into separate and component forces of distinct origin, or assuming or contemplating such a division, are to that extent revoked.

3. The insignia now prescribed for the Regular Army shall hereafter be worn by The United States Army.

4. All effective commissions purporting to be, and described therein as, commissions in the Regular Army, National Guard, National Army or the Reserve Corps shall hereafter be held to be, and regarded as, commissions in The United States Army—permanent, provisional or temporary, as fixed by the conditions of their issue; and all such commissions are hereby amended accordingly. Hereafter during the period of the existing emergency all commissions of officers shall be in The United States Army and in staff corps, departments and arms of the service thereof, and shall, as the law may provide be permanent, for a term, or for the period of the emergency. And hereafter during the period of the existing emergency provisional and temporary appointments in the grade of second lieutenant and temporary promotions in the Regular Army and appointments in the Reserve Corps will be discontinued.

5. While the number of commissions in each grade and in each staff corps, department and arm of the service shall be kept within the limits fixed by law, officers shall be assigned without reference to the term of their commissions solely in the interest of the service; and officers and enlisted men will be transferred from one organization to another as the interests of the service may require.

6. Except as otherwise provided by law, promotion in The United States Army shall be by selection. Permanent promotions in the Regular Army will continue to be made as prescribed by law.

(320 A. G. O.)

By order of the Secretary of War,
PEYTON C. MARCH,
General, Chief of Staff.

Official:
H. P. McCAIN,
The Adjutant General.

THE SELECTIVE SERVICE LAW AND PHYSICIANS.

Many letters have been received concerning the relation of the new Selective Service Law to physicians. A few of these letters have been selected to be answered in the Queries and Minor Notes department. It may be said that, as a general proposition, there is no difference between the new and the old Selective Service Law except as to the ages included and the slight broadening of the terminology concerning exemptions. With special exceptions, all male persons who are above 18 years of age and have not reached their forty-sixth birthday on September 12 must register. The exceptions are those who have registered under the previous draft acts, whether or not called for service; officers and enlisted

men of the Regular Army; officers appointed and men of the forces drafted under the previous draft act; "officers and enlisted men of the National Guard while in the service of the United States; and the officers of the Officers' Reserve Corps and enlisted men in the Enlisted Reserve Corps while in the service of the United States; and officers and enlisted men of the Navy and Marine Corps and officers and enlisted and enrolled men of the Naval Reserve Force and Marine Corps Reserve while in the service of the United States." As we have stated before, there are in the United States 75,000 physicians, including those already commissioned, under 46 years of age. The question of greatest interest is the disposition of physicians after their registration. There is nothing in the bill, as we read it, that provides for any different method of applying the selective service principles than that which has heretofore governed the disposition of those under 31 years of age. The Selective Service Boards are the only bodies empowered under the law to grant exemptions. Undoubtedly special regulations concerning physicians will be promulgated by the Provost Marshall-General. It is quite probable that in formulating these regulations the Provost Marshall-General will consult some or all of the Surgeon-Generals of the various services. As we stated last week, the problems of adequately providing for the medical needs of the Army and Navy and of the civil population are more complex than those affecting any other occupation, because of the great demand and the somewhat limited supply. Last week we outlined these demands, and it is not necessary to repeat them. The one question asked in most of the letters received is, What constitutes dependency so far as physicians are concerned? It has been suggested that physicians could not advance a plea for exemption on the grounds of dependency, since they are eligible for a commission, which would give an income sufficient to support a small family in fair circumstances. Local boards in some communities have refused to exempt physicians on the grounds of dependency for this reason; on the other hand, the opposite principle has been carried out by other local boards. In view of the large number of physicians now affected, these matters will no doubt also be considered in the special regulations concerning physicians.

MEDICAL PREPARATION FOR THE IMPENDING DRAFT.

The following circular letter, dated August 22, was addressed to the Medical Aides to the Governors by Col. F. R. Keefer, chief of the Medical Division of the Provost Marshall-General's Office:

1. It is anticipated that, pursuant to legislation now pending, a very large registration will be made in September.

2. As the entire work incident to this new draft must necessarily be compressed within a very few weeks, the machinery of the draft must be repaired, oiled, and otherwise put in perfect condition to function at high speed and with efficiency.

3. It must not be said afterward that the medical parts of the machine were weaker than the rest, nor that their slow or imperfect action resulted in delay.

4. To the end that the greatest efficiency may be had, therefore, and the greatest credit accrue to those concerned with the medical operations of the draft, Medical Aides are instructed immediately to establish closer relations with all medical examiners; to urge on them the enormous importance of the matter; to make them realize that the coming test will be the greatest in the history of the draft; and to impress on them the fact that the efficiency of our overseas armies depends vitally on the way in which the test is met by THEM.

5. A careful but rapid survey must be made of all medical examiners of Local Boards. Weak examiners must be replaced; slow ones must be speeded up. Assistance must be arranged for where needed. All must be made to realize the emergency.

6. Medical Advisory Boards must be instructed that examinations must be promptly made, and the papers returned at once. All examiners must be made aware that defects which are obvious even to a layman, reflect discredit on the board as well as on the system.

7. Analysis of causes of rejection at mobilization camps will indicate weaknesses of individual boards, and suggest the proper remedy.

8. Where not already carried out, Medical Aides will arrange for meetings of medical examiners from a number of boards. These should be addressed by the Medical Aides, or by some competent examiner designated by the Aide. By selecting such men with care, they may be established as consultants, to whom examiners may refer for advice.

9. A force of inspectors has recently been organized in connection with the draft. The Provost Marshall-General contemplates that these inspectors shall, as a part of their duties, make inquiries concerning the knowledge of Medical Aides as to the efficiency and preparedness of their medical examiners throughout the state.

10. The medical profession, in its intimate relation to the draft, has met and discharged its obligations for the most part in an admirable manner. It must not fail now.

MEDICAL MEMBERS OF LOCAL AND DISTRICT APPEAL BOARDS.

A number of the medical members of local and district appeal boards have resigned to accept commissions in the Medical Corps of the Army; more than a hundred were commissioned during the month of July. While their action in the great majority of cases has been prompted by purely patriotic reasons, some undoubtedly have acted in the belief that they would be subject to draft under the new Selective Service Law, and preferred to secure commissions before being called. These resignations have already seriously crippled many of the boards. It is for this reason that the Provost Marshal-General has taken action to prevent as far as possible such resignations in the future. It must be remembered that the Selective Service Law, in creating

these boards, is specific in defining the functions of the members and the punishment for neglect of duty. The regulations state that members of these boards are as effectively "drafted for this duty as are registrants who are selected for military service." The only way in which a member of a local or district appeal board may resign is by application for relief directly to the governor of the state. The governors have now been asked not to accept such resignations, and draft boards have been cautioned not to release necessary medical members without the sanction of the Provost Marshal-General. The needs of the Provost Marshal-General's Office are regarded as paramount, and the Surgeon-General is requesting local examiners for the Medical Reserve Corps, in forwarding papers of applicants, to indicate whether or not the applicant is a member of a Selective Service board. Undoubtedly, if there is a competent examiner available to take the place of the one who desires to resign, the resignation will be accepted. These comments apply to medical members of local and district appeal boards only; not to members of medical advisory boards.

WOMEN NEEDED AS RECONSTRUCTION AIDES IN OCCUPATIONAL THERAPY.

Trained women as teachers in occupational therapy are needed immediately for service in military hospitals, about 1,000 being desired for overseas service within the next few months. These reconstruction aides will teach hand crafts and other subjects to disabled soldiers in the military hospitals. The qualifications for this service are: age, between 25 and 40; citizens of the United States, or subjects of the allied countries; physical fitness; height not less than 60 inches nor more than 70; weight, not less than 100 nor more than 196 pounds; a thorough general education, at least the equivalent of graduation from a secondary school—college graduates preferred; an expert in some line. These aides will be divided into three classes: aides, head aides and supervisors, one head aide being responsible for the work of every ten aides, and a supervisor being appointed where there is need for more extended supervision. The salary of the aides will be $50 per month for service in the United States, and $60 for service abroad, the head aides receiving $15 additional. Transportation and $4 for other traveling expenses are also provided. For service at home a hospital uniform is required; for foreign service both hospital and street uniforms are needed. Women qualified for the service are requested to send applications at once to the Office of the Surgeon-General, Attention Division of Physical Reconstruction, Washington, D. C.

STATE AND COUNTY COMMITTEES V. M. S. C.

The Central Governing Board of the Volunteer Medical Service Corps of the Council of National Defense announces that the Wisconsin State Executive Committee of the Volunteer Medical Service Corps is comprised of the following doctors:

H. M. Brown, M. D., Chairman, 79 Wisconsin St., Milwaukee.

G. A. Harlow, M. D., Secretary, Northwestern Mutual Life Ins. Co. Bldg., Milwaukee.

C. H. Vilas, M. D., Madison.

W. T. Sarles, M. D., Sparta.

L. F. Jermain, M. D., Majestic Bldg., Milwaukee.

The purpose of this Committee is to co-operate with the Central Governing Board in prosecuting all activities pertaining to the mobilization and enrollment of members of the Volunteer Medical Service Corps throughout the state.

The Central Governing Board of the Volunteer Medical Service Corps also authorizes the appointment of one county representative in each county in every state of the Union. The county representatives for Wisconsin are as follows:

(Select name of your county representative from county list enclosed.)

WISCONSIN.

Ashland, Bayfield, Iron—J. M. Dodd, Ashland.

Barron, Polk, Washburn, Sawyer, Burnett—I. G. Babcock, Cumberland.

Brown, Kewaunee—W. W. Kelly, Green Bay.

Calumet—I. N. McComb, Brillion.

Chippewa—C. A. Hayes, Chippewa Falls.

Clark—E. L. Bradbury, Neilsville.

Columbia—A. F. Schmeiling, Columbus.

Crawford—R. M. White, Prairie du Chien.

Dane—C. R. Bardeen, Madison.

Dodge—F. T. Clark, Waupun.

Door—T. C. Proctor, Sturgeon Bay.

Douglas—L. A. Potter, Superior.

Dunn, Pepin—L. A. Larsen, Colfax.

Eau Claire—R. E. Mitchell, Eau Claire.

Fond du Lac—G. B. McKnight, Fond du Lac.

Grant—J. C. Bets, Boscobel.

Green Lake, Waushara, Adams, Marquette—J. S. Walbridge, Berlin.

Green—W. S. Monroe, Monroe.

Iowa—J. R. Hughes, Dodgeville.

Iron—(See Ashland Co.)

Jackson—(See Trempealeau Co.)

Jefferson—G. L. Smith, Lake Mills.

Juneau—A. T. Gregory, Elroy.

Kenosha—G. F. Adams, Kenosha.

Kewaunee—(See Brown Co.)

La Crosse—D. S. McArthur, La Crosse.

La Fayette—C. C. Gratiot, Shullsburg.

Langlade—J. C. Wright, Antigo.

Lincoln—H. G. Hinckley, Merrill.

Manitowoc—J. F. Pritchard, 220 N. 8th, Manitowoc.

Marathon—W. A. Green, Wausau.

Marinette, Florence—

Marquette—(See Green Lake Co.)

Milwaukee—Daniel Hopkinson, 1009 Third, Milwaukee.

Monroe—W. T. Sarles, Sparta.

Oconto—C. E. Armstrong, Oconto.

Oneida—E. R. Boyer, Rhinelander.
Outagamie—M. J. Sanborn, Appleton.
Ozaukee—Charles A. Balkwill, Grafton.
Pepin—(See Dunn Co.)
Pierce—R. U. Cairns, River Falls.
Polk—(See Barron Co.)
Portage—W. W. Gregory, Stevens Point.
Rice, Taylor—G. A. Weichman, Rib Lake.
Racine—Susan Jones, Racine.
Richland—R. H. DeLap, Richland Center.
Rock—E. B. Brown, Beloit.
Rusk—J. C. Baker, Hawkins.
Sauk—Frank D. Hulburt, Reedsburg.
Sawyer—(See Barron Co.)
Shawano—W. H. Cantwell, Shawano.
Sheboygan—Arthur E. Genter, 516 N. 8th, Sheboygan.
St. Croix—E. L. Boothby, Hammond.
Taylor—(See Pierce Co.)
Trempealeau, Jackson, Buffalo—G. N. Heidershide, Arcadia.
Vernon—F. E. Morley, Westby.
Vilas—(See Oneida Co.)
Walworth—E. Kinne, Elkhorn.
Washburn—(See Barron Co.)
Washington—N. E. Hausman, Kewaskum.
Waukesha—B. Caples, Waukesha.
Waupaca—G. T. Dawley, New London.
Waushara—(See Green Lake Co.)
Winnebago—F. G. Comnell, Oshkosh.
Wood—W. M. Ruckle, Grand Rapids.

WAR NOTES

Dr. C. J. Rollefson of Superior has been visiting at home on a furlough. He is stationed at Americus, Ga.

Lieut. Charles E. Rydell, formerly a practicing Superior physician, is now with the American Expeditionary forces in France, according to a letter which has come to his father, Jacob Rydell, 528 Tower avenue. Dr. Rydell is a member of the Medical Reserve corps and left Superior in September. He went first to Ft. Benjamin Harrison, Ind., thence to Camp Pike, Mo., and next to an embarkation hospital in Virginia. His next move was to Allentown, Pa., whence he was sent overseas.

Dr. P. G. McGill of Superior entertained at luncheon August 3rd for Capt. W. A. McEachern, previous to his departure for Ft. Riley, after a brief furlough. The Superior profession attended the luncheon in a body.

Dr. J. S. Reeve of Appleton has been appointed to succeed Dr. Frank Brockway as Medical member of the Eastern Wisconsin District Board.

Dr. N. P. Mills of Appleton will occupy the office and care for the practice of Capt. V. F. Marshall, who has entered the service.

Capt. Gerhard A. Bading, former mayor of Milwaukee, has been ordered to the Philippines where he will become attached to the medical corps, according to a postal received from Honolulu by City Clerk Leuch on Monday. Capt. Bading was formerly stationed at Deming, N. M.

Dr. J. M. Beffel of Milwaukee, who is in France, writes of the Milwaukee Base Hospital as follows: "The health of the unit is excellent. We are getting nicely settled. Our freight is coming fast and in a short time the hospital will be fully equipped, the first in this unit. I have been made sanitary inspector for the whole camp. No man who serves in this war can have any regret. Our service is one to establish freedom for a whole world."

Dr. Augstrom, formerly of Canada, will look after the work of Dr. E. H. Damrow of Janesville, in service.

Dr. G. A. Ribenack, formerly of Colfax, has taken over the work of Dr. W. O. Seeman of Eau Claire, who is at Ft. Riley for training.

Dr. W. E. Nelson of the Kenosha Health Department has enlisted in the Sanitary Corps.

Capt. A. J. McCarey of Green Bay is with Ambulance Co. 19, and has been through the fighting at Chateau Thierry. He writes with pride of the brave part our men played in this battle which stopped the Hun advance.

Dr. Leon H. Flancher, formerly senior physician at Muirdale, now in the service, has been promoted to a Captaincy.

Dr. Robert H. Gray of La Crosse, who enlisted as a Lieutenant, has been promoted to a Major.

Dr. R. B. Smiley of Stevens Point, now in the service, has been promoted to a Captaincy.

Late in July a call was received from Provost Marshall General Crowder for 49 physicians of draft age who had been classified for limited service, to report to Columbus Barracks Aug. 15th. The call was immediately sent to Local Boards by the Adj. General. Of the 49 men, it was found that 46 were members of the Reserve Corps, and were in active service. This is a record of which Wisconsin may be proud.

The first United States soldier to be killed in the war and the first to be wounded were both in the medical corps. This fact must have impressed the American people with the serious risks which are taken by army doctors. Before we entered the war the bravery and sacrifice of medical officers at the front had probably been too little appreciated. As a matter of fact the officers and enlisted men in the medical corps are the only soldiers who go into no man's land with no defense whatever. The tireless work on the battle field of the stretcher bearers all of whom are in the medical corps, is full of danger.

Medical members of local and medical advisory boards are urged to remain at their posts, in a letter sent to all draft boards today by Gov. Philipp. Local boards have lost a few of their assisting examiners because they enlisted in the Medical Reserve corps, and the governor wishes to have each physician who intends to enlist hereafter consult with him first. He says the situation in this respect is critical as the state has been pretty well drained of doctors.

Dr. Homer Sylvester, Base Hospital, Camp Pike, Little Rock, Ark., has been promoted and placed in entire charge of orthoepedics in camp and hospital. He is also a member of a number of consulting boards. Dr. Sylvester has recently been chosen for overseas service.

COMMISSIONS AWARDED.

W. L. Stephenson, Ladysmith.
H. T. Schlegel, Wausau.
W. O. Seeman, Eau Claire.
S. G. Pake, Hayward.
M. A. Froney, Racine.
W. T. McNaughton, Milwaukee.
J. R. Cunningham, Tonapah.
A. J. Gates, Tigerton.
C. A. Hefty, New Glarus.
J. A. E. Eyster, Madison.
Neil Andrews, Oshkosh.
R. C. Faulds, Abrams.
H. P. Neis, Gilman.
G. A. Wilske, Milwaukee.
R. G. Arveson, Frederick.
D. C. Harrison, Mason.
N. A. Peterson, Soldiers Grove.
F. J. Hinckley, Stanberry.
J. C. Elsom, Madison.
G. C. Waufle, Janesville.
T. L. Harrington, Milwaukee.
C. W. Giesen, Superior.
V. E. Ekblad, Superior.
G. T. Hegner, Appleton.
Aug. Westedt, Loganville.

ORDERED INTO SERVICE.

A. W. Gray, Milwaukee, to Camp Grant.
V. F. Marshall, Appleton, Ft. Oglethorp.
F. B. Taylor Madison, Camp Sherman.
G. F. Kenney, Milwaukee, Ft. Oglethorp.
Dana Dishmaker, Kewaunee, ———
G. C. Waufle, Janesville, Camp Custer.
W. E. Ground, Superior, Central Dept.
C. C. Post, Barron, Camp Humphrey.
J. T. Klein, Milwaukee, Camp Grant.
W. O. Seeman, Eau Claire, Ft. Riley.
E. H. Damrow, Janesville, Camp Greenleaf.
W. A. Munn, Janesville, Ft. Riley.
W. J. Winnemann, Athens, Camp Sherman.
W. T. McNaughton, Milwaukee, Waco, Texas.
L. L. Taylor, Waupun, Central Dept.
H. T. Schlegel, Wausau, Ft. Oglethorp.

RECENT ORDERS ISSUED TO WISCONSIN PHYSICIANS IN SERVICE.

To Camp Dodge, Des. Moines, Iowa, for duty, from Fort Leavenworth, Capt. John R. Eastman, Kenosha.

To Camp Grant, Rockford, Ill., base hospital, Capt. Alfred W. Gray, Milwaukee; Lieut. John C. Zuercher, La Crosse.

To Camp MacArthur, Waco, Texas, base hospital, from Fort Oglethorpe, Capt. Gentz Perry, Amery.

To Camp Meade, Admiral, Md., base hospital, from Camp Crane, Lieut. Charles B. Rydell, Superior.

To Camp Pike, Little Rock, Ark., for duty, from Fort Sheridan, Capt. Charles E. Launder, Viroqua.

To Fort Des Moines, Iowa, base hospital, from New York, Lieut. Earle F. McGrath, Appleton.

To Fort Oglethorpe for instruction, Capts. Victor F. Marshall, Appleton; Herbert A. Robinson, Kenosha; William S. Darling; Lieuts. Walter G. Darling, George F. Kenney, Stanley J. Seeger, Milwaukee.

To Fort Riley for instruction, Capt. Frank W. McKee, Richland Center; Lieuts. Joseph A. Keithley, Palmyra; Samuel C. McCorkle, West Allis.

To Fort Worth, Texas, for duty, from Fort Sill, Capt. Richard S. Wilson, Milwaukee.

To New Haven, Conn., for duty, Capt. Lewis W. Dudley, Milwaukee.

To Rockefeller Institute for instruction in bacteriology, and on completion to Army Medical School for duty, Lieut. Beverly M. Hall, Milwaukee.

To Washington, D. C., for duty in the Surgeon-General's Office, from Camp Kearney, Major John R. McDill, Milwaukee.

To Army Medical School for instruction, and on completion to Fort Oglethorpe, from Chicago, Capt. E. L. Bolton, Chilton.

To Camp Devens, Ayer, Mass., base hospital, from Camp Custer, Capt. G. Senn, Green Bay; from Camp Shermau, Capt. S. W. Doolittle, Lancaster.

To Camp Dodge, Des Moines, Iowa, for duty, from Fort Brady, Capt. G. R. Randall, Milwaukee.

To Camp Grant, Rockford, Ill., base hospital, Lieuts. J. T. Klein, H. J. Kuhn, Milwaukee. For duty, from Fort Riley, Lieut. E. N. Pfeffer, Milwaukee.

To Camp Lee, Petersburg, Va., with the board examining the troops for cardiovascular diseases, from Lakewood, Lieut. E. S. Gatterdam, La Crosse.

To Camp MacArthur, Waco, Tex., for duty, from Fort Oglethorpe, Lieut. C. M. Sonnenburg, Sheboygan.

To Camp Meade, Admiral, Md., base hospital, from New York, Lieut. C. C. Birkelo, Rosholt.

To Camp Pike, Little Rock, Ark., for duty, Capt. A. L. C. Borchardt, New London; from Camp Zachary Taylor, Lieut. C. B. Hake, Milwaukee.

To Fort McHenry, Md., base hospital, from Camp Dix, Lieut. E. R. F. Murphy, Antigo.

To Fort Oglethorpe, as instructors, from Fort Riley, Capt. F. J. Woodhead, Merton; Lieut. E. I. Moquin, Fairwater. For instruction, Capt. J. W. Powers, Burlington; Lieuts. E. K. Thompson, Cudahy; from duty as a private, Lieut. A. C. Nugent, Milwaukee.

To Fort Ontario, N. Y., base hospital, from New York, Lieut. T. F. Laughlin, Winneconne.

To Fort Riley for instruction, Lieuts. R. L. MacCormack, Alma Center; J. M. Mecum, Bagley; J. E. Twohig, Fond du Lac; J. Rosholt, La Crosse; P. M. Ross, E. A. Scholter, W. A. Sickels, Milwaukee.

To New Haven, Conn., Yale Army Laboratory School, for duty, Lieut. F. M. Harris, Fond du Lac.

To Newport News, Va., for duty, from Camp Wadsworth, Lieut. E. G. Linkman, Milwaukee; from Fort Oglethorpe, Lieut. G. G. Wallchlaeger, Milwaukee.

To report to the commanding general, Central Department, for assignment to duty, Capts. E. J. Phelps, Elderon; F. Walters, Stevens Point; W. E. Ground, Superior.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion to Jefferson Barracks, Lieut. F. H. Russell, Neenah.

To Rockefeller Institute for instruction in laboratory work, and on completion to Army Medical School, for duty, Capt. F. A. McJunkin, Milwaukee. For instruction in the treatment of infected wounds, and on completion to his proper station, from Camp Dix, Lieut. T. C. H. Abelmann, Watertown.

The following order has been revoked: To Washington, D. C., American University, for duty, from Fort Oglethorpe, Lieut. O. W. C. Maercklein, Wauwatosa.

To Azalea, N. C., for duty, from New Haven, Lieut. A. A. Pleyte, Delafield; Lieut. E. P. Allen, Waukesha.

To Camp Custer, Battle Creek, Mich., base hospital, Capt. W. Ackerman, Milwaukee; Lieut. G. C. Wanfle, Janesville. For duty, Lieuts. F. G. Dutton, Green Bay; G. A. Thielke, Wausau.

To Camp Grant, Rockford, Ill., base hospital, Lieut. J. B. Vedder, Marshfield. For duty, Lieut. M. A. Froney, Racine.

To Camp Hancock, Augusta, Ga., base hospital, from Fort Riley, Capt. W. P. Forkin, Chilton.

To Camp Joseph E. Johnston, Jacksonville, Fla., for duty, from Fort Oglethorpe, Lieut. C. N. Sonnenburg, Sheboygan.

To Camp Sevier, Greenville, S. C., base hospital, Lieut. J. N. Doyle, Princeton.

To Camp Sherman, Chillicothe, Ohio, base hospital, Lieut. A. J. Weber, Milwaukee.

To Fort Oglethorpe for instruction, Lieuts. L. A. Hoffman, Campbellsport; P. C. Hodges, Madison; W. G. Sexton, Marshfield.

To Fort Riley for instruction, Capt. H. A. Jefferson, Clintonville; Lieuts. H. J. Crambling, Milwaukee; C. A. Hefty, New Glarus.

To Fort Sam Houston, Tex., for duty, from Fort Riley, Lieut. C. H. Oliver, Boyerville.

To Madison University, Wis., for duty, Major J. A. E. Ryster, Madison.

To Plattsburg Barracks, N. Y., for duty, from Fort Slocum, Capt. S. Blanton, Madison.

To Rochester, Minn., Mayo Clinic, for instruction and on completion to Camp Dodge, Des Moines, Iowa, base hospital, Capt. E. L. Masen, Eau Claire.

The following order has been revoked: To Camp Meade, Admiral, Md., base hospital, from Camp Crane, Lieut. C. B. Rydell, Superior.

To Camp Crane, Pa., from Camp Custer, Capt. H. S. Roby, Milwaukee.

To Camp Dodge, Iowa, Capt. W. L. Stephenson, Ladysmith.

To Camp MacArthur, Texas, Lieut. W. T. McNaughton, Milwaukee.

To Camp Meade, Md., from Fort McHenry, Lieut. E. R. F. Murphy, Antigo.

To Camp Wheeler, Ga., from Camp Cody, Capt. J. S. Foat, Ripon.

To Fort Benjamin Harrison, base hospital, from Fort Oglethorpe, Lieut. J. Anderson, Racine.

To Fort Oglethorpe for instruction, Capts. N. Andrews, Oshkosh; A. O. Sanders, Superior.

To Fort Riley for instruction, Capts. W. O. Seeman, Eau Claire; D. G. Harrison, Mason; E. F. Bickel, Oshkosh; N. A. Peterson, Soldier's Grove; Lieuts. J. J. Malcolm, Chetek; W. A. Munn, Janesville; W. W. Coon, Milton Junction; O. T. Gunther, Sheboygan; R. F. Fitch, Tomah.

To New Haven, Conn., Lieut. L. F. Ruschhaupt, Milwaukee.

To Newport News, Va., from Camp Meade, Lieut. C. C. Rowley, Winnebago.

To report to the commanding general, Central Department, Capts. J. C. Elsom, Madison; L. L. Taylor, Waupun.

To Camp Crane, Pa., from Camp Upton, Lieut. A. T. Johnson, Sauk City; from the Surgeon-General's Office, Major R. H. Ivy, Milwaukee.

To Camp Dodge, Iowa, Capt. W. L. Stephenson, Ladysmith; Lieuts' E. A. Lapham, Rib Lake; G. Parke, Viola.

To Camp Greene, N. C., to examine the troops for cardiovascular diseases, from Camp Lee, Lieut. E. A. Gatterdam, Wauwatosa.

To Camp Joseph E. Johnston, Jacksonville, Fla., base hospital, from Fort Oglethorpe, Capt. B. F. Hoyt, South Kaukauna.

To Camp Sherman, Ohio, as tuberculosis examiner, from Fort Benjamin Harrison, Capt. H. C. Mix, Green Bay.

To Fort Oglethorpe for instruction, Capt. C. W. Giesen, Superior; Lieuts. K. H. Trippett, Buckhannon; R. G. Hays, Friendly; J. F. McNary, Milwaukee; H. T. Schlegel, Wausau.

To Fort Riley for instruction, Capts. W. H. Finney, Clintonville; W. M. Gratiot, Mineral Point; F. C. Haney, Watertown; Lieuts. P. Leicht, Lake Mills; A. C. Niemann, New Holstein.

To Markleton, Pa., from New Haven, Capt. L. W. Dudley, Milwaukee.

To Mineola, N. Y., from Madison, Major J. A. E. Eyster, Madison.

If a lizard be drowned in the urine of any man, then shall the lust of venery be quenched in that man, and the same shall be, if he drink of doves dung mixed with wine and oil. (Zimara.)

VENEREAL DISEASE CONTROL.

W. F. Snow and W. A. Sawyer, Washington, D. C., (*Journal A. M. A.*, Aug. 10, 1918), discuss the control of venereal diseases in the Army. They are spread essentially by contact, and while the problem is simplified by the fact that they do not exist in the lower animals, and are not carried by them, nor is their transfer by inanimate objects common, as the germs tend to die out rapidly away from the human body, another important fact bearing on the methods of control is that disease carriers are common who seem well and regard themselves as so, but who are nevertheless capable of infecting others. Control of venereal diseases has been inadequate in civil life because most health authorities have felt little responsibility for them, though, taken altogether, not even tuberculosis is a greater public health problem. In the Army they exceed all other communicable diseases in numbers and disability caused, as is shown by charts which, however, need interpretation. The annual rate as recorded for the first time in a given week, is reckoned by the actual number of cases multiplied by 52, as an annual rate is required instead of a weekly rate, and divided by the total number of men in thousands to obtain the rate per thousand, and it would be a grave error to quote the figures in such a way as to give the impression that fifty-two infected men had been discovered in every thousand in one week. Newly drafted men bring in a large number of cases as compared with the astonishingly small number contracted after the men are in uniform. It must be pointed out that the disease brought into the Army is the accumulated uncured disease of the newly enlisted men, in some cases of years standing. The explanations of the charts are quite full and intelligible. The relatively large amount of these diseases brought by colored troops is notable, and must be reckoned with in any plan for control. Before the present war the principle emphasis was placed on the instruction of the soldier against exposure, and the use of early prophylactic treatment. The Army had little success in persuading civilian communities to aid. At present matters are better. At least twice a month every soldier is inspected, and if infected is put under treatment. He is restrained to the camp as long as he is a carrier, loses his pay while disabled, and is punished if he refuses to take the early, or prophylactic, treatment. He is questioned also as to the source of contagion and the information is turned over to the civilian health authorities to co-operate in the work. Infection of the soldier involves the civilian and in the greater part the civilian is responsible. The details of co-operation by public health agencies are described. In thirty-four states and one territory these infections are obliged to be reported. Over five-sixths of the cases in the figures that have been obtained were contracted before enlistment, and the prophylactic regulations are applicable to civilian communities and should be generally adopted. The control of such disorders as a group forms the greatest public health problem of today, and the one that gives most promise of solution in the immediate future. Nine charts accompany the article.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

Officers 1917-18

G. WINDESHEIM, Kenosha, President
OSCAR LOTZ, Milwaukee, 1st Vice President
T. W. NUZUM, Janesville, 2nd Vice President

CARL DOEGE, 3rd Vice President
ROCK SLEYSTER, Waupun, Secretary

DANIEL HOPKINSON, Milwaukee Ass't Secretary
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1st Dist., M. R. Wilkinson - Oconomowoc
2nd Dist., G. Windesheim - - Kenosha

TERM EXPIRES 1918

3rd Dist., F. T. Nye - - - - Beloit
4th Dist., W. Cunningham - Platteville

TERM EXPIRES 1919

5th Dist., W. F. Zierath - Sheboygan
6th Dist., H. W. Abraham - Appleton

TERM EXPIRES 1920

7th Dist., Edward Evans - LaCrosse
8th Dist., T. J. Redelings - Marinette

TERM EXPIRES 1921

9th Dist., Joseph Smith - Wausau
10th Dist., R. U. Cairns - - River Falls

TERM EXPIRES 1922

11th Dist., J. M. Dodd - - Ashland
12th Dist., D. J. Hayes - - Milwaukee

Delegates to American Medical Association

H. M. BROWN, Milwaukee
ROCK SLEYSTER, Waupun
C. H. LEMON, Milwaukee

Alternates

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T. W. NUZUM, Janesville
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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES.

County.	President.	Secretary.
Ashland-Bayfield-Iron	M. S. Hosmer, Ashland	C. J. Smiles, Ashland.
Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
Brown-Kewaunee	A. O. Olmsted, Green Bay	E. G. Nadeau, Green Bay.
Calumet	W. C. Schmitz, School Hill	E. L. Bolton, Chilton.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	L. H. Prince, Madison	W. H. Sheldon, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	G. C. Nedry, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	G. B. McKnight, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	R. E. Flynn, La Crosse	Jens Rosholt, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Schockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. E. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	Louis Falge, Manitowoc.
Marathon	W. E. Zilisch, Wausau	F. H. Frey, Wausau.
Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. H. Fellman, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	A. R. Bell, Tomah	S. D. Beebe, Sparta.
Oconto	C. W. Stoelting, Oconto	T. C. Clarke, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	E. R. Boyer, Rhinelander.
Outagamie	J. J. Laird, Black Creek	M. J. Sandborn, Appleton.
Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
Pierce	W. A. Lumley, Ellsworth	Rollo Cairns, River Falls.
Portage	D. N. Alcorn, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	G. C. Wichman, Rib Lake.
Racine	G. W. Nott, Racine	Susan Jones, Racine.
Richland	R. H. Delap, Richland Center	G. Benson, Richland Center.
Rock	M. P. Andrews, Beloit	E. B. Brown, Beloit.
Rusk	J. C. Baker, Hawkins	L. M. Lundmark, Ladysmith.
Sauk	F. D. Hulburt, Reedsburg	Roger Cahoon, Baraboo.
Shawano	J. B. Gordon, Shawano	W. H. Cantwell, Shawano.
Sheboygan	H. C. Reich, Sheboygan	T. J. Gunther, Sheboygan.
St. Croix	B. Kunny, Baldwin	O. H. Epley, New Richmond.
Trempealeau-Jackson-Buffalo	Wm. Belitz, Cochrane	C. F. Peterson, Independence.
Vernon	J. K. Schreiner, Westby	F. E. Morley, Viroqua.
Walworth	M. D. Cottingham, Lake Geneva	E. Kinne, Elkhorn.
Washington	H. F. Weber, Newburg	A. H. Heidner, West Bend.
Waukesha	G. E. Peterson, Waukesha	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	J. W. Lockhart, Oshkosh	E. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Ruckle, Grand Rapids.

SOCIETY PROCEEDINGS

FOND DU LAC COUNTY

The Fond du Lac County Medical Society held a banquet at the Elk's Club Monday, August 12 at seven o'clock P. M. in honor of Doctor Elmer Twohig before his leaving for service in the Medical Reserve Corps. Captain S. E. Gavin was present and talked on his experiences at Camp Colt.

F. M. McGauley, *Secretary.*

NINTH COUNCILOR DISTRICT.

The summer meeting of the Ninth Councilor District Medical Society was held at Waupaca, Thursday, August first. Following a dinner served at the Inn Hotel at six-thirty, the following program was given: Laboratory Aids in Diagnosis, Doctor V. A. Mason; Cancer of the Rectum, Doctor E. V. Smith; Medical Experiences in France, Doctor T. B. Smith.

W. B. Sexton, *Secretary.*

CONFERENCE OF HEALTH OFFICERS.

A most successful meeting of the Health Officers of Wisconsin was held in the Assembly Chamber, Madison, August 7th and 8th. Addresses and papers were given by Doctors C. A. Harper, W. D. Stovall, Frank R. King, Dorothy Reed Mendenhall, Magnus Swenson, L. E. Spencer, G. E. Hoyt, I. F. Thompson, L. Dorpat, G. W. Henika, L. W. Hutchcroft, G. C. Ruhland, E. B. Brumbaugh and A. H. Broache.

ASSOCIATION NEWS

ANNOUNCEMENT AND PRELIMINARY PROGRAM OF THE STATE MEDICAL SOCIETY OF WISCONSIN, MILWAUKEE, OCTOBER 2-4, 1918.

The seventy-second annual meeting of the State Medical Society of Wisconsin will be held in Milwaukee, October 2, 3 and 4. When it is announced that the arrangements made for last year's meeting will be duplicated, those who attended in 1917 will need no further assurance of a repetition of the most successful meeting of our Society ever held.

The arrangement committee has again secured the Auditorium for the meeting. The growth of the Society in recent years and its division last year into section meetings make necessary this arrangement as no other building in the state can house the various activities of the organization under one roof and no other city in Wisconsin can furnish hotel accommodations to comfortably care for the five or six hundred men who now register at our meetings. All of the Auditorium rooms which will be used are on the first floor and are accessible through the East entrance. The general sessions of the Society will be held Wednesday and Thursday afternoons and Friday morning in Juneau Hall. The section meetings will be held Wednesday and Thursday mornings in rooms adjacent. The commercial exhibit will be on a par with those of previous meetings and will be found in Kilbourn Hall.

In accordance with the often expressed wishes of many of the members who prefer to have one evening to attend theaters, visit friends and relatives or hold reunions, there will be no set program for Wednesday evening. The annual dinner will be served in Milwaukee's new Athletic Club Thursday evening. Wives and families of physicians in attendance are cordially invited to attend. The program will be in keeping with the highest traditions of the Society and with the patriotic spirit of the times.

The arrangement committee has been fortunate in securing the use of the "Mayo Endowment Scientific Exhibit" just as it appeared at the last meeting of the American Medical Association.

The scientific program which follows is one to tempt any man away from the year's grind. The war has made this an unusual year, loading the profession down with responsibilities which must be met and can be met only through the closest kind of team work. Many matters of importance to the profession and to you individually must be decided at this meeting. You owe it to your country, to yourself, to your profession and to your patients to come to Milwaukee in October and take your part in this meeting. Make your plans now to attend the full session, returning home Friday night.

MEMORANDA.

1. The House of Delegates will meet in the Gold Room of the Hotel Wisconsin (which will be headquarters) Tuesday evening, October 1st, at eight o'clock. Delegates must register before the meeting. Please see to it that your society is represented.

2. The first section meetings will be held in the Auditorium Wednesday morning at nine o'clock

and the first general session, Wednesday afternoon at two o'clock.

3. The registration and information desk will be located immediately to the right of the east entrance to Kilbourn Hall where the commercial exhibits will also be found. Report there on your arrival and receive your badge. This is the only record of attendance and the badge is necessary for entertainment features.

4. The Commercial Exhibit will be in Kilbourn Hall of the Auditorium.

5. The Mayo Endowment Scientific Exhibit will be found in Kilbourn Hall.

6. *Entertainment.* The annual dinner and entertainment for visiting physicians and their families will be held in the Milwaukee Athletic Club Thursday evening. Wednesday evening has been left open for attending theater parties, reunions, etc., without compunction of conscience so far as a set program is concerned.

7. On registering, you will designate your preference for the Medical, Surgical or Eye, Ear, Nose and Throat section, though you may of course attend the different sections as the program appeals to you.

8. *A reminder.* If you have not paid your dues it is clearly your duty to do so now. The names of delinquents will be dropped from the roll of the Society and the mailing list of the Journal October first and you must be in good standing to register at the meeting.

9. On Tuesday, October 1st, the Wisconsin Surgical Association will hold an all day clinic at the Milwaukee County Hospital. A luncheon will be served at noon and all members of the State Medical Society are invited to attend.

PRELIMINARY PROGRAM.

General Sessions.

October 2d, 2 P. M.

1. Address of the President,
   Dr. G. Windesheim, Kenosha.
2. Health Supervision of Children Working Under a Permit,
   Dr. George C. Barth, Director of School Hygiene, Milwaukee.
3. ————
4. *Address in Medicine*—Thyroxin,
   Dr. Henry S. Plummer, Rochester, Minnesota.

October 3d, 2 P. M.

5. Eye, Ear, Nose and Throat—subject of general appeal,
   Dr. Joseph C. Beck, Chicago.
6. Cardiac Disturbances from the Standpoint of Military Service,
   Dr. J. S. Evans, Madison.
7. Surgical Paper,
   Past Asst. Surgeon Drew Luton, Great Lakes Naval Training Station.
8. *Address in Surgery,*
   Army officer not yet assigned.

October 4th, 9 A. M.

9. Hospital Standardization,
   Dr. J. M. Dodd, Ashland.
10. Health Insurance,
    Prof. J. R. Commons, Madison.
11. Compulsory Health Insurance,
    Dr. E. H. Ochsner, Chicago.

Surgical Section.

October 2d, 9 A. M.

1. Cysts of the Mesentery,
   Ralph M. Carter, Green Bay.
   Discussion—Warren E. Leaper, Green Bay; H. P. Rhode, Green Bay.
2. Psychoneuroses and Surgery,
   Herman E. Wolf, La Crosse.
   Discussion—M. J. Cleary, Kenosha.
3. Common Gynecologic Errors,
   Chester M. Echols, Milwaukee.
   Discussion—M. J. Cleary, Kenosha; J. S. Thomas, Milwaukee.
4. Indications for Davis Caeserian Section,
   R. W. Roethke, Milwaukee.
   Discussion—L. A. Fuerstenau, Milwaukee; M. L. Henderson, Milwaukee.
5. Bunion—Its Cause and Cure,
   Herbert A. Robinson, Kenosha.
   Discussion—Edward Ochsner, Chicago; F. J. Gaenslen, Milwaukee.

October 3d, 9 A. M.

6. Mesenteric Thrombosis,
   Joseph F. Smith, Wausau.
   Discussion—Edward Evans, La Crosse; C. E. Lemon, Milwaukee.
7. Etiology of Banti's Disease or Splenic Anemia.
   H. J. Kristjanson, Milwaukee.
   Discussion—W. C. F. Witte, Milwaukee; M. C. McJunkin, Milwaukee.
8. Subject to be announced,
   H. A. Sifton, Milwaukee.
9. Hydronephrosis: Its Diagnosis and Treatment,
   James C. Sargent, Milwaukee.
   Discussion—E. A. Fletcher, Milwaukee; Fred A. Stratton, Milwaukee.

Medical Section.

October 2d, 9 A. M.

1. Atropin and Dextrose Solution in the Treatment of Acute Bowel Obstruction Where Operation is Refused,
   Dr. A. J. Caffrey, Milwaukee.
2. Modern Treatment of Rectal Diseases,
   Dr. J. Donovan, Milwaukee.
3. A Plea for the Adequate Treatment of Syphilis,
   Dr. J. J. Seelman, Milwaukee.
4. Digitalis in Cardio-Renal Disturbances,
   Dr. O. M. Layton, Fond du Lac.

October 3d, 9 A. M.

5. Early Symptoms of Organic Brain and Spinal Cord Disease,
   Dr. D. W. Roberts, Milwaukee.
6. Notes on Some Medico Legal Cases,
   Dr. Richard Dewey, Wauwatosa.
7. Foods, Fads and Facts,
   Dr. H. P. Greeley, Madison.
8. Grave Anemias Associated with Focalized Infections,
   Dr. F. C. Rinker, Madison.

Eye, Ear, Nose and Throat Section.

(Announcement later.)

CLINICAL MEETING OCTOBER 1st.

The Wisconsin Surgical Association will hold clinics at the Milwaukee County Hospital Tuesday, October 1st (the day preceding the meeting of the State Society). The program outlined is as follows:

1. E. A. Fletcher, Renal Functional Tests.
2. F. J. Gaenslen, Orthopedic Surgery.
3. L. F. Jermain, Medical Diagnosis.
4. M. L. Henderson, Gynecology.
5. W. C. F. Witte, Surgery.

A noon luncheon will be served at the Hospital. All members of the State Medical Society are invited to attend these clinics. It will require your coming to Milwaukee but one day earlier and the first meeting of the House of Delegates will be held that evening.

NEWS ITEMS AND PERSONALS

St. Joseph's Hospital at Marinette celebrated a Silver Jubilee anniversary on August 9th; a new training school for nurses has been opened by the sisters. A committee was appointed to raise funds for the institution.

Dr. E. W. Pickard succeeds Dr. W. D. Krebs at Shawano. Dr. Pickard was formerly located at Cecil.

Dr. John G. Barnesdale of Superior was recently found guilty, by a jury in the U. S. District Court, of violation of the Harrison Drug Act. He was sentenced to 3 years in prison and fined $6,000.

Dr. E. M. Barton has been appointed to succeed Dr. A. W. Gray as Chief of the Milwaukee Fresh Air Pavilion.

Census Bureau compilations just published show Wisconsin as the lowest typhoid death rate in the Union—6.7 per 100,000 population.

The latest attempt of the heirs of the late Antoinette Keenan to break her will, in which she leaves the greater part of her estate to establish free medical dispensaries in Milwaukee, has failed, according to the decision of Judge Turner.

Dr. J. E. Meany has been elected Secretary of the Manitowoc County Medical Society, to succeed Lr. Louis Falge, deceased.

Dr. Crone of Manitowoc succeeds Dr. Aldridge at Two Rivers, who has left for New York.

Dr. M. A. Lee of Superior has been elected Chief Medical Examiner of the Sons of Norway.

The Marquette Medical School drive for the Carnegie endowment secured $450,488. The Milwaukee Chamber of Commerce has assumed the responsibility of raising the balance of the fund needed.

Milwaukee is fourth in health among 46 of the largest American cities.

Lawrence College at Appleton will establish, this year, a pre-medical course.

Dr. G. Windesheim, president of the State Medical Society, has been appointed full-time health commissioner for the city of Kenosha.

Platteville has been quarantined as the result of an epidemic of infantile paralysis.

Miss Eva Colyer, Supt. of nurses at St. Agnes Hospital, Fond du Lac, has entered the service as a Red Cross nurse.

Health Commissioner Ruhland of Milwaukee hopes to employ nurses on a half-time basis. Several married women who were nurses have volunteered to take the places of nurses who have left the service on account of the war. However, they wish to work only half a day.

A. H. Stange of Merrill has offered a site and $50,000 toward a hospital for that city.

Dr. H. L. Wilson has been appointed Deputy Health Officer of Racine. He comes from Chicago.

The following officers were elected by the Tri-State Medical Society at its Madison meeting:

Honorary president, Dr. James W. Guthrie, Dubuque.
President, Dr. L. H. Prince, Sparta.
First vice-president, Dr. H. J. Langworthy, Dubuque.
Second vice-president, Dr. C. R. Bardeen, Madison.
Third vice-president, Dr. W. B. Helm, Rockford.
Managing director, Dr. W. B. Peck, Freeport.
Secretary and treasurer, Dr. D. G. Smith, Freeport.

The committee on Social Insurance, appointed by the last legislature, will hold meetings in the Milwaukee Common Council Chamber during the State Fair.

A Child Welfare Conference was held in Eau Claire during the last week of August.

The La Crosse County School of Agriculture, one of the pioneers in that field of education in the Northwest, may be closed because of the war, and the building converted into Tuberculosis Sanatorium to care for soldiers afflicted with that disease.

Establishment of Pay Clinics throughout the country, to release physicians for army duty, and at the same time to enable the civilian population to secure adequate and skilled medical service at a cost within their reach, is being urged by Cleveland, Ohio, physicians.

27 Polish girls have completed the preparatory training course for Gray Samaritan nurses at the Y. W. C. A. in Milwaukee.

The 4th Biennial Conference of Wis. Health officers was held in Madison Aug. 7th and 8th, and attended by several hundred local health officers.

Dr. C. H. Vilas has donated a large Victrola to the new Madison Tuberculosis Sanatorium which he established on Lake Monona.

The Milwaukee Maternity Hospital is laying plans for a drive for funds, to be held sometime in September.

William George Bruce, general secretary of the Milwaukee Association of Commerce, wrote letters Saturday to the Adjutant General of the United States army at Washington, D. C., and to the Surgeon General asking that one of the sixteen convalescent and reconstruction hospitals for American soldiers which it is understood the government is about to build, be located somewhere between Milwaukee and Waukesha, saying that climate and topographical conditions both warranted such a location for one of these humane institutions. There is plenty of government-owned ground at the National Soldiers' home, it is claimed, upon which one of these buildings could be placed, and the location is central to Wisconsin and the West. The ground is high, the climate healthful; the proximity to Milwaukee, a convenience not to be overlooked in the choice of a good site.

Plans have been drafted for three new cottages at the Blue Mound sanatorium and work will be begun on them in about two weeks. It is expected they will be ready for use before winter. When completed they will allow of the treatment of eighty patients instead of forty at the sanatorium. The infirmary at the sanatorium is under roof and will be completed in about two weeks. A new drive is being completed around the sanatorium grounds.

Eleven teachers and college graduates will make up Wisconsin's pioneer class of public health instructors that begins training Sept. 10. The purpose of the course, originated by the Wisconsin Anti-Tuberculosis association, is to provide the state with trained public health workers to offset the inevitable drain resulting from the enlistment of large numbers of doctors and nurses in military service. Well educated young women will be equipped for health work in schools, city health departments, laboratories, and other organized agencies.

In addition to the regular insurance allowed men who have been discharged from the army for physical causes, the government stands ready to pay for the maintenance and treatment in sanatoria of all discharged tuberculous soldiers. This is the statement of Col. Charles E. Banks, chief medical advisor of the Bureau of War Risk Insurance, who has been in Wisconsin during the past week to investigate the sanatorium resources of the state.

The Jefferson county board has authorized purchase of the John Widman farm of 160 acres, adjoining the county farm on the south. Twenty acres will be used as a site for the proposed tuberculosis sanatorium, for which a $50,000 bond issue was authorized for building and shacks at the spring meeting. The committee in charge of the sanatorium project has selected Otto Uehling, Milwaukee, as its architect.

The board of directors of the Milwaukee Maternity hospital will ask for a ninety-day extension of the order to vacate its quarters in the old Plankinton homestead which has been purchased by the Jesuit order as a site for an extension of the Marquette university. The order to vacate was to take effect Sept. 1.

A new record in births has been established in Milwaukee Maternity hospital Wednesday, seven babies being born in 24 hours, according to Mrs. G. A. Hipke, superintendent. The fathers of many of these are in France, Mrs. Hipke says, and the hospital has six more applications from "war mothers" whom the association will care for free of charge.

To meet the need for well trained women nurses, both during the war and afterward, the departments of medicine and home economics at the University of Wisconsin are offering courses, which are recognized by law as approved laboratory courses for prospective nurses, and have arranged a course of study whereby the requirements for the certificate of registered nurse may be secured in the shortest possible time.

Because of difficulty in obtaining money, labor and material, erection of the disposal plant of Milwaukee's $15,000,000 sewage system, under construction, has been postponed for duration of the war.

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and
MRS. LOUISE BRAND, Milwaukee

THE HEALTH OFFICER AND THE BIG FIGHT.

It is said to take nine men working "over here" to keep one soldier fighting "over there." Clearly, therefore, it is wise to keep the nine workers husky and working as well as the one soldier.

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war-strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, Oct. 14-17, to be held under the auspices of the American Public Health Association. Some of the military sanitarians who will address the meetings are Surgeon General Gorgas, Colonel Victor C. Vaughan, and Major William H. Welch of the Army Medical Corps. Other speakers at the general sessions will be George H. Vincent, president of the Rockefeller Foundation, Dr. Charles J. Hastings, president of the American Public Health Association, Dr. W. A. Evans, Assistant Surgeon General, Allan J. McLaughlin, U. S. P. H. S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, Dr. Frederick L. Hoffman and others.

There will also be papers upon laboratory, industrial hygiene, vital statistics, food and drugs, sanitary engineering, sociological, and general health administration subjects.

As the health of the civil population has a direct bearing upon the winning of the War, mayors and governors are being requested to send their health officers to the conference in spite of the present high cost of government.

The final program will appear in the American Journal of Public Health appearing Sept. 25. For further information write to A. W. Hedrich, Secretary, American Public Health Association, 1041 Boylston St., Boston, Mass.

WISCONSIN PUBLIC HEALTH LABORATORIES—HOW TO USE THEM.

Diphtheria is one of the few diseases which is ideal for the use of preventive measures. We know much about it. The cause, mode of spread, the cure, and prevention are commonly known. Still it is not controlled as it can be. In Wisconsin last year there were approximately 4,000 cases of diphtheria. It can be cured, yet it caused in our state last year 326 deaths.

That means that the disease was spread from one person to another by people who either had just recovered from the disease, temporary carriers, or by people who had not had the disease but who had diphtheria bacilli in the nose or throat or both, chronic carriers. It means that although we know that people recovering from diphtheria may carry diphtheria bacilli in the nose and throat for long periods after recovery, the information has not been used.

If every person who has had diphtheria were kept isolated until cultures showed that they no longer carried diphtheria bacilli, if cultures were made from the nose and throat of every person who has been exposed to diphtheria and immediately isolated if these cultures showed diphtheria bacilli, and finally if every case of sore throat were treated as if it were diphtheria until bacteriological diagnosis proved it not to be, in two years there would be not a single case in Wisconsin.

Now is the time when we can least afford to have epidemics of any kind, and particularly of a disease which we know very well how to prevent. The physician who sees a suspicious sore throat and does not take immediate steps to prevent the spread of diphtheria until a bacteriological diagnosis is made, does not fulfill his duty as a "Stay at Home" to either the community or the soldier, who comes back and forth to visit friends and relatives, nor the soldiers in the camp to which this soldier returns.

In order to be of as much assistance as possible, the state laboratories are keeping a record of all cases of diphtheria, and if we do not receive release cultures from these cases within a week or ten days after the diagnosis, the physician who has charge of the case is sent the following letter:

Dear Doctor:

We gave you a positive diagnosis for diphtheria on ——— patient. Since then we have received no other cultures.

Your attention is called to the ruling of the State Board of Health which says:

"Every person convalescent from diphtheria must remain isolated until two successive cultures from the throat and nose made not less than 24 hours apart show the absence of diphtheria bacilli."

Very truly yours,

This is simply to remind the physician that no case of diphtheria can, under the law, be released from isolation until negative cultures are obtained. The city or village is required to stand the expense of obtaining the release cultures.

CORRESPONDENCE.

Dr. P. H. writes:

I have sent two swabs to you in the case of B. G. The first one was negative and the second positive. It seems strange that I should get a positive report after getting the negative one.

Ans. A negative report does not mean that the patient did not have diphtheria. If a negative report is received in a suspected case of diphtheria, another swab should be carefully taken. If a membrane is present it should be loosened and the swab rubbed between the membrane and tonsillar surface. If the second swab is reported negative, it is not a case of diphtheria. Such instances are rare, and do not happen when the swab is properly taken.

Dr. S. A. writes:

A good many of my throat cultures are reported contaminated. What does that mean?

Ans. It means that bacteria which are not associated with diseased conditions of the throat or nose have grown in the media. They get in the media if the swab, as it is removed from the package, touches the outside of the container or the fingers. Sometimes it is unavoidable. If you receive many such reports your method of making the culture is at fault.

Dr. P. S. writes:

Received a report on the swab, which read No Growth. I am glad to know that the patient did not have diphtheria.

Ans. This is not the correct interpretation of the report. "No Growth" indicates that the swab was not infected and that another swab should be taken.

TAKING AN INVENTORY OF OUR HEALTH RESOURCES.

Quite aside from the valuable information which is being compiled, the state health survey which is being conducted by the Health and Recreation Department of the Women's Committee of the Wisconsin State Council of Defense gives every promise of proving one of the most important and far-reaching bits of home defense work that has been undertaken by the women of the state. The taking of the survey was inspired by the belief that an intelligent understanding of existing health conditions, disease problems and health resources in each community was essential to the formation of a constructive program for health conservation, that the war-time health problem was merely the peace-time health problem intensified, and that all effort to guard communities against increased disease dangers due to war conditions and the shortage of doctors and nurses should be so directed that it would be of permanent benefit to the state.

"To strengthen one's defenses, one must know where the weak spots are" is the slogan borne by the survey, the first section of which is practically an inventory of the existing agencies in each community which can be utilized in public health work. Special inquiry is made as to the enforcement of the state laws requiring the quarantining and placarding of contagious diseases, the reporting of births and certain diseases and local health ordinances.

It is believed that the survey is the most comprehensive ever undertaken by amateurs and in the method which has been adopted for securing the survey material lies one of its unique values. Under the leadership of Mrs. E. F. Bickel of Oshkosh, state chairman of the Department of Health and Recreation, and Mrs. H. H. Morgan, general chairman of the Woman's Committee, the work has been organized by counties, the county chairman being responsible for the taking of the survey in the territory under her jurisdiction. Each county chairman has been instructed to appoint a local committee in every city, village, and township and blanks and letters of instruction have been furnished each committee. The outlines for the survey were prepared and the blanks were printed for the State Council of Defense by the Wisconsin Anti-Tuberculosis Association, whose office force will also assist in the work of tabulation.

"If the survey never accomplishes anything more than the education of local committees, by pointing out to the women how inadequate the present health machinery is in most communities and how little attention has been paid to the protection of health in most counties, it will have more than justified itself as an important piece of war work," declared one social worker, enthused by the zeal with which the majority of the local committees have undertaken the work. . L. B.

TO EXAMINE CHILDREN ENTERING SCHOOL.

Wisconsin physicians will be asked to assist in a state-wide campaign which is to be inaugurated this fall as an important feature of the follow-up work in the Children's Year program and which will seek to secure a medical examination for every school child entering kindergarten or first grade in schools which have no kindergarten. Convinced that the physical examination of school children would safeguard them from many of the defects which, neglected in childhood, have been responsible for the rejection of so large a percentage of the young men of draft age by military examining boards, the Child Welfare Department of the Woman's Committee of the Wisconsin State Council of Defense is concentrating much of its effort on securing agencies for health work in the schools. The employment of at least one county nurse in every county in the state is being urged and private duty nurses are being urged to take training for public health work in one of the public health courses conducted in Milwaukee by the Wisconsin Anti-Tuberculosis Association.

The movement for the complete medical examination of every child entering school for the first time is designed to reach every community in the state, those which have no school physician or nurse as well as those which have. It has the cordial endorsement of State Supt. C. P. Cary, who will issue a bulletin to superintendents and principals authorizing the work. At the same time local Child Welfare committees will be instructed by the state department to confer with the school authorities and offer their services in securing the necessary equipment and professional assistance.

Women interested in the movement would be glad to see it extended to include the examination of all school children and hope that this may result ultimately. It was felt that if it was started by examining the comparatively few children who enter school each year, the work involved would not be burdensome to the physicians in any community and that their co-operation could readily be secured by the defense council committees. The intention is to provide record cards which would follow the children through the various grades and be available for future data. L. B.

TO THE GRADUATE NURSES OF WISCONSIN: WISCONSIN NEEDS MORE PUBLIC HEALTH NURSES.

Since war was declared many public health nurses have volunteered for military duty so that ranks which never were adequately filled are still more depleted.

The Children's Bureau in its program to save 100,000 babies this year is demanding that committees should engage a public health nurse.

The draft has shown that many of the physical defects among men could have been corrected by good school nursing in their boyhood years. The result has been that the public is aroused as never before to the need of medical inspection and good school nursing.

Rural nursing and industrial nursing is increasing greatly, and who but the tuberculosis nurse can teach the family the rules of isolation and disinfection that minimize the danger to the rest of the family.

The visiting nurse has her great work to do in caring for the sick in their homes. They not only care for the patient, but they teach the principles and practice of right living, visiting about six or eight patients a day. It is the duty of the public at this time of stress to utilize the visiting nurse instead of the private duty nurse wherever possible so that the private nurse may be released for duty in the public health field.

Every private duty nurse, who on account of family ties or some other reason cannot join the Red Cross Nursing Service for military duty, should most earnestly consider the needs of this great war service at home in the public health field. This is one great way that you can help.

For this work the Wisconsin Anti-Tuberculosis Association is prepared to give to graduate nurses

and senior student nurses, two courses of four months each, the first beginning the early part of September and the second in February. The Chicago School of Civics and Philanthropy, in co-operation with several of the public health nursing agencies of Chicago, offers two splendid courses for public health nurses, one of eight months and one of four months in length.

Will you not give this your earnest consideration as the part that you will undertake in the winning of this great war?

If you are interested, communicate with Mrs. Kate Kohlsaat, R. N., Superintendent of the Milwaukee Visiting Nurses Association and professional representative of the Council of State Representatives of the National Organization for Public Health Nursing.

PREVENTION OF MENINGITIS, DIPHTHERIA AND OTHER INFECTIOUS DISEASES IN THE ARMY CANTONMENTS.

Some exceedingly interesting work on the prevention of the infectious diseases originating in the nasopharyngeal tract is being done by army surgeons at various cantonments.

For instance, in an article on "Meningitis at Camp Greene," contributed by Capt. Paul G. Woolley, to the Journal of Laboratory and Clinical Medicine for April, the statement is made that "In the only organization which made use of systematic nasal sprays since the first of the year, not a single case (of meningitis) developed, and also that in those organizations in which sprays were resorted to after the appearance of the disease no other cases appeared." The spray used at this camp was Dichloramine-T. Captain Woolley says that after this experience "one comes to have a very healthy respect for Dichloramine-T as an agent for the prevention of diseases of upper respiratory tract origin." He adds: "The organization numbered 7 in the chart has had the lowest measles and pneumonia rate in Camp Greene and is the only one which has systematically used the nasal spray. Its record is striking, and forms a reasonable basis upon which to recommend that the routine use of nasal spraying with Dichloramine-T be introduced into the camps for the prophylaxis of respiratory diseases."

Virtually, the same method of treatment was employed by Major Carey P. McCord, Major Alfred Friedlander and Capt. Robert C. Walker, at Camp Sherman, in the treatment of diphtheria, in an article published in the July 27th issue of the Journal of the American Medical Association, in which they state that in the treatment of these carriers they inaugurated the use of Chlorazene. They employed "an aqueous solution of 0.25 per cent. strength, administered as a gargle three or four times daily. In certain cases, the application was made by throat specialists to insure the reaching of remote points in the nasopharynx. The gargling was followed with an oily spray of Dichloramine-T of 2 per cent. strength. It may not be maintained that the Chloramin action is exclusively responsible for the appreciable reduction of days in hospital of carriers. This is in part due to the Chlorazene-Dichloramine-T treatment and in part to the general painstaking systematizing of the entire care of such patients. Through the use of these several described procedures, it has been possible to return the carriers to duty after an average of twenty-three days in hospital. During the month of May our systematizing of treatment made it possible to discharge all diphtheria patients (sixteen in number) after fifteen days in a hospital, and all carriers (twenty-nine in number) after sixteen days in hospital."

The combined use of aqueous Chlorazene solution and the oil solution of Dichloramine-T promises to be of utmost value, not only in preventing diphtheria and meningitis, but also as a prophylactic in pneumonia, measles, streptococcic sore throat and the other diseases originating in the nasopharyngeal tract.

Chlorazene and Dichloramine-T are manufactured by, and obtainable from The Abbott Laboratories, Chicago, Illinois.

A BLESSING.

By Edgar W. Jordan.

May The Powers That Be abundantly bless mine enemies—for they have been of such inestimable benefit to me.

Mine friends have delivered unto mine ears the things I would hear—and which were of no value to me, for they but reflected the past which is dead—with all but its lessons, which I have learned—more or less imperfectly.

Mine enemies, when they would have wounded me, did but apply the goad that was necessary to spur me to a greater sense of duty. They made possible to me the acquisition of certain thoughts, at certain times, and these have measured largely in guiding me along the pathway that does not lead to remorse. When these, mine enemies, would have scored me they but opened mine eyes to a clearer vision—Oh, Powers That Be, bless them and prosper them accordingly!

Mine friends have come to me with honeyed words of praise—for which I may gently blame them—for naught was accomplished thereby, except, perchance, the relaxing of the vigilance of my conscience.

Mine enemies have applied the bitter lash of criticism—and, verily, but it was good. To such I owe whatever of worthiness I may possess that fits me to make acquaintanceship with grief and worthy to meet sorrow upon terms of familiarity.

Be very good unto mine enemies, Oh Powers, for they have extended my horizon—and, indeed, the mountains are good to look upon.

THE TUBERCULOSIS SOLDIER.

E. H. Bruns, Washington, D. C. (*Journal A. M. A.*, Aug. 10, 1918), says that it is the consumptive soldiers' misfortune that he gets no due recognition, though his breaking down with tuberculosis may mean that he has given every ounce of resistance to his country's cause. The ultimately bad result in the treatment of tuberculosis is usually due to the perfunctory way in which patients are discharged from the sanatorium. Prolonged rest is essential in the treatment of active cases, and naturally leads to laziness. We start out with a sick consumptive and end up with a well loafer. In the Army the tuberculous soldier becomes a hospitalized pensioner. When the patient also becomes an arrested or quiescent case, he usually leaves before the hardening up process is completed and his cure thoroughly tested. He often does not want to be rehabilitated, and the fact of his having been consumptive may be against his finding occupation. Soldiers can be beneficiaries of a soldiers home as long as treatment is required, and after that there is no authority to keep them. These points have been emphasized to Bruns by the years' experience at Fort Bayard, New Mexico, the Army consumptive sanatorium. The remedy he suggests is less emphasis on rest, when it is not absolutely essential, and the introduction of vocational training a real future and not a sham for the patient. It would, the author thinks, change the whole atmosphere of the tuberculosis hospitals and make them more popular and easier to administer. The present policy of the Surgeon-General is to transfer all tuberculosis soldiers to Army tuberculosis hospitals, and not discharge them until they become arrested and reconstructed cases, or until they have obtained as complete recovery as can be expected. Eight such hospitals are now in operation or under construction. Soldiers would generally prefer discharge to the hospital; it is intended, therefore, to order all to the hospitals where they can be taught to take care of themselves, and where they will receive proper treatment. The success of these hospitals will depend on the qualifications of the medical officers in charge, and a training school for such officers has been established where all thus assigned must take instruction. Educational work in the tuberculosis hospitals will be in the way of vocational training, together with training in hygiene, home and shop sanitation and methods of proper living, and a bill is now before congress providing that when a patient is discharged and returns to civil life the Federal Board of Vocational Education will attend to his further rehabilitation. It is also stipulated in the bill that the War Risk Bureau is to have the power and duty of ordering suitable discharged men to follow such courses as the Federal Board of Vocational Education shall prescribe and provide. It is believed that most patients with arrested cases can return to their former occupations excepting those employed at hard manual labor, very dusty trades, mining, etc. It is not always necessary to have the work outdoors, but they should be employed and live under good sanitary conditions and their work carefully controlled by medical supervision.

PRESYSTOLIC THRILL.

R. S. Morris (Cincinnati), Lakewood, N. J., and Alfred Friedlander, Camp Sherman, Chillicothe, Ohio (*Journal A. M. A.*, Aug. 3, 1918), say that in the course of their work as cardiovascular examiners they were impressed by the finding of presystolic thrills in recruits in whom they could detect no other evidence of valvular disease. The thrill is one of short duration, felt only at the apex of the heart preceding the apex thrust and ending with the shock of the first sound. It is never, in their experience, as intense as the thrill felt in well marked cases of mitral stenosis, and it is best felt when the heart's action is accelerated and is always lost in recumbency of the patient. With a slow, quiet action of the heart it is commonly lost even in the erect posture. A systolic, apical shock of variable intensity is palpable immediately after the thrill, and with presystolic thrill they find almost constantly a reduplication of the first sound at the apex and usually also at the tricuspid area. It also decreases or is lost in lying down. They have not been able to detect presystolic murmurs either before or after exercise or with the subject standing or recumbent. They believe that the services of many soldiers have been lost to the government by the rejection on account of this functional thrill. They find that it has been already noticed elsewhere by Sewall and others and is a normal phenomenon in a certain proportion of healthy adults.

PERICARDITIS.

H. A. Christian, Boston (*Journal A. M. A.*, Aug. 10, 1918), has noticed in his experience the very great frequency of the occurrence of abnormal physical signs of the left lower lobe of the lung in cases which ordinarily would be diagnosed as cases of acute or fibrinous pericarditis, because of the presence of a to-and-fro friction rub. He has seen fifty-three cases, almost all adults, in whom the diagnosis of acute pericarditis was made because of an audible pericardial friction rub. Thirty-nine of them showed definite physical signs in the left lower back, dulness of varying extent and usually bronchial breathing and bronchophony. The signs appear to be due to compression of the pulmonary tissue of the left lower lobe and moderate amounts of pleural fluid are often demonstrated. Compression either from the heart or pericardium or from the pleural fluid or both appears to be the main cause. Intrapulmonary changes of an inflammatory nature may also play a part, but this is not proved. The frequency of these signs and their localization on the left suggest some causal relationship to the acute pericarditis. The pulmonary signs exert little influence on the course of the disease and the prognosis. Almost all of the patients recover, except those in whom the pericarditis was a terminal event in some more or less chronic condition. In no case was there evidence of extensive pericardial effusion, and tapping in a few cases brought out no fluid.

FURUNCULOSIS AND ITS TREATMENT, ESPECIALLY BY MEANS OF YEAST.

Skillern in his comprehensive article "The Rational Treatment of Furuncles" (Jour. A. M. A., Sept. 16, 1911, Vol. LVII, Number 12) gives us a general picture of the pathology of the furuncle, and then goes on to describe in detail the treatment. He states that a furuncle, as described by Da Costa is "an acute and circumscribed inflammation of the deep layer of the true skin, and the subcutaneous tissue following bacterial infection of a hair-follicle or a sebaceous gland." The causative organism, he states, is usually staphylococcus aureus. The organisms burrow down into the hair-follicle, and invading the adjacent sebaceous gland, excite the surrounding subcutaneous tissue to inflammatory defensive reaction. Congestion, local collection of leucocytosis, swelling of the neighboring lymph-nodes, fever and malaise follow in more or less rapid succession, associated with ulceration of the skin near the hair-follicle, liquefaction necrosis of the follicle and the surrounding tissue, and final escape of sero-pus and a white slough; this entruding of the slough occurs, when the furuncle has been left to nature, about the seventh day after the onset of the local symptoms.

Skillern recommends that in the prophylaxis of furunculosis the rules of general hygiene be followed, especially the hygiene of the skin. Diabetes may be a predisposing cause.

Skillern recommends as surgical treatment suction of the individual boil by means of a Bier's vacuum cup (but not squeezing with the operator's fingers, which only produces undue trauma) and the keeping of the parts moist by the use of a 1% solution of sodium citrate in normal saline solution on sterile gauze. The gauze should be renewed every four hours and kept under waxed paper or oiled silk. The neighboring skin should be protected by a suitable ointment.

If the furuncle is seen early enough, attempts may be made to abort it by the swabbing of its center as deeply as possible with carbolic acid on the cotton of an appropriate applicator; or several drops of liquefied phenol may be injected right at the base of the furuncle. Only if the patient presents himself for treatment when there is well-marked softening and fluctuation of the tissues resulting from a boil should an incision be made. Otherwise, the knife should be withheld (except perhaps to excise the boil in certain cases) on the ground that it does not shorten the process of repair, interferes with the good work of the serum and the defensive leucocytes, and leaves an unnecessary scar. The author does not employ flax seed poultices, because they devitalize the tissue and leave unsightly scars. The use of corrosive sublimate solution for combatting furuncles is condemned on the ground that it lowers the resistance of the tissues and does not penetrate to the depths of the wound.

Medically, sodium citrate is employed internally in doses of 15 grains three times a day, after meals, both for its alkaline action on the blood, and for its diuretic action on the kidneys. Occasionally, too, thiosinamine is given in doses of 1½ gr. three times a day to hasten the subsidence of the enlarged lymph nodes.

Antistaphylococcic serum may be injected near the infected area twice a week to promote passive immunity or active immunization is carried on by the well-known vaccine treatment. Skillern uses a stock vaccine, or preferably an autogenous vaccine, made of 400,000,000 killed bacteria per C.C.^{3} of salt solution. Of this latter an initial dose of 0.25 C.C.^{3} is given, and injections are given at weekly intervals, the doses increasing until 2.5 C.C.^{3} are administered at one time.

It is especially on the re-occurrence of boils or of crops of boils (furunculosis) that these injections become necessary. Skillern states that "the next best treatment of recurrent furunculosis is by yeast (Saccharomyces albicans), which stimulates phagocytosis and liberates cabonic acid, thus recalling John Hunter's recommendation of carbonate of sodium for boils. While brewer's yeast (oberhefe) is inelegant pharmaceutically, is a nauseating substance, and is hard to keep and to handle, yet it has strong advocates. I have seen furunculosis checked by the use of nuclein in the assimiable form of compressed tablets.

In a subsequent article (New York Medical Journal, Dec. 19, 1914, p. 1218), Skillern lays stress on a proper diet in the prophylaxis and treatment. He quotes Francis, a British author who states that "I have known cases where abstention from eggs has resulted within a fortnight in freedom from boils, crops of which had previously succeeded one another without a break." Skillern had evidently found that there was no one ideal medical treatment of furuncles, infallible in every case, for he recommends very highly sulphurous acid in teaspoonful doses in water, three times a day after meals. He had treated a long series of cases in this manner without any recurrence of boils. His experience with sulphurous acid was the outcome of his knowledge that sulphur in some form had long been of use in the treatment of furunculosis, either as the powder, or as calcium sulphide or in the form of sulphuric acid.

Whatever the results of treatment of furunculosis by other methods have been, it is probable that they have not surpassed those of Hawk and collaborators who in an article entitled "The Use of Bakers' Yeast in Diseases of the Skin and of the Gastro-Intestinal Tract" (Jr. A. M. A., Vol. LXIX, No. 15, Oct. 13, 1917), publish the result of their treatment of furunculosis and other skin conditions with Compressed Yeast (Fleischmann's). The use of fresh bakers' yeast brought about an improvement or cure in 16 of 17 cases of furunculosis, as well as in a case of folliculitis, and in other skin conditions. The cases were followed up weeks to months, after cessation of treatment, without recurrence of furunculosis. One of the cases had previously been treated with vaccines. Fleischmann's Compressed Yeast may be taken in water, beef-tea, or orange juice, and there is no reason why it could not be administered spread on bread. The doses usually administered were ½ to 1 cake three times daily. Some of these patients had been suffering with boils for a long period of time. Usually the cases were cured or boils considerably improved within 2 weeks after the administration of the first dose. Sometimes, because of gas formation in the gastro-intestinal tract, it was necessary to kill the yeast cells just before administration by

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immersing the cake for a few minutes in boiling water.

Hawk concludes that "bakers' yeast was found to be a useful remedy in the treatment of furunculosis, acne vulgaris, acne rosacea, constipation, and in certain other cutaneous and gastro-intestinal conditions," and that "we consider that yeast is fully as successful as any other remedy in furunculosis, acne vulgaris, and acne rosacea."

Numerous investigators before Hawk had attested to the beneficial effects of yeast in furunculosis. Among these was Brocq (Presse med., Jan. 28, 1899, p. 45), who among other cases, treated himself with it for furunculosis. Brocq was preceded in his use of it by, among others, Lassar (Semaine Medicale, 1899, p. 56) who (Ref. in Deutsche med. Wochenschrift, 1906, p. 1906) had used it successfully in the treatment of 30 cases of furunculosis. He obtained good success with it in the furunculosis of diabetics.

The yeast employed by Lassar and by Brocq was the ordinary yeast of the breweries. Brocq himself in another article (Journ. med. et chir. pratique, 1900, p. 898) acknowledged that the action of brewers' yeast was not uniform, different samples varying very much in action.

The vaccine treatment of furunculosis is not always successful, although it is based on rational principles, and has ardent advocates. In this connection we may mention that one of the numerous ways yeast is supposed to act therapeutically is by its favorable action on the opsonic index. The U. S. Dispensatory cites Walzou and Sacharow as having injected yeast into dogs and having noted a subsequent rise of the opsonius against streptococci and staphylococci: Huggard and Moreland (Lancet, part 1, June 3, 1905, p. 1493) employed it clinically in cases of tuberculosis and noted a considerable rise in the opsonic index, presumably against the tubercle bacillus.

One of the latest editions of American text-books (Pusey, 1917) has this to say about the vaccine treatment of furunculosis: "Since Wright's original suggestion there has been the widest use of vaccines in the treatment of furuncles, as in other forms of pus infection. I have very little confidence in the method. Certainly it fails in a great many cases." In the vaccine treatment, the best results have been obtained from the use of autogenous vaccines. It must be remembered that means for making these are not always at hand.

Yeast has been found valuable in the furunculosis of diabetes, in fact, it has been used as a remedy in diabetes itself. It has also been used in the infectious diseases, as well as in the furunculosis that follows such diseases as typhoid fever. Schamberg (1915) using brewers' yeast, was not able to ascribe to it a good effect in the furunculosis accompanying variola, although he advocates it in cases of ordinary furunculosis.

One of the beneficial influences that yeast may exercise in furunculosis is the influence on the constipation that may accompany it.

A woman that hath before miscarried, shall drink, if she be again pregnant, of the milk of a bitch, and she shall then mature her conception. (Zimara.)

THE SOFT ANSWER THAT TURNETH AWAY WRATH.

A stock promoter recently wrote to some of our members, as follows:

"Dear Doctor ————:

"———— Will you do me a favor? I want you to write me a letter and tell me frankly why you have not bought stock in our company. I am very anxious to know what has prevented you from taking advantage of our offer and I will appreciate it if you will tell me, etc., etc.,

"Yours for final action."

This is one of the letters the promoter received. We fancy it was some "answer" and some "final":

October 9, 1917.

Mr. ————.

Dear Sir:

Sure I'll do you "a favor." (By the way, you can "go some.") I haven't bought any of your "wall paper" for several reasons, among which are:

1. The fact that anybody who has any stock to sell that's worth a damn doesn't offer it to doctors—simply because he doesn't have to—and "capital" rarely let the "good things" go out of the family.

2. The chances of winning out in the other fellow's promotion game are about 500 to 1 against; therefore, as an investment, a lottery, or even craps has you beat a city block. As for the traditional celluloid dog with wax legs chasing the asbestos cat through hell, his job is a sinecure compared with the position of the fellow who hacks the average stock promotion scheme.

3. Because I was "vaccinated" years ago, and therefore, am an immune.

4. Because, according to the best authorities, the moon is not made of green cheese.

By the way, publish this letter. Most of the 140,000 suckers who are practicing medicine in America (each is a "prospect") know something of me, and the publication of this might help you sell your stuff. Mother Eve would have fallen several days sooner if she had had something to "warn her." Go to it, me laddie buck, and oblige me by saving your stamps by omitting me from your mailing list.

Incidentally, you did "save" one. When business men ask one to correspond with them relative to their own interests they usually enclose a stamp for reply. A two-cent stamp put into your scheme, of course, is a reckless investment. But, then, I am a good sport and have charged mine off to amusements.

Very truly,

G. FRANK LYDSTON.

OLD INNER TUBES FOR ICE BAGS.

Old inner tubes have been employed by Kirk W. Holmes, Colchester, Conn. (*Journal A. M. A.*, Aug. 10, 1918), for ice bags. He finds them even better than the regular bags, which quickly get out of order and are expensive. Parts cut lengthwise and sterilized can be utilized in emergencies, and in the absence of other rubber tissue, for drains and impervious coverings.

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ORIGINAL ARTICLES

ADDRESS OF THE PRESIDENT AT THE 72ND ANNUAL MEETING OF THE STATE MEDICAL SOCIETY OF WISCONSIN.

BY G. WINDESHEIM, M. D.,
KENOSHA.

Mr. Chairman, Ladies and Gentlemen, Guests, and Members of the State Medical Society of Wisconsin:

Appreciating as I do the great honor you have bestowed upon me by selecting me to fill the highest position in the ranks of the Medical Profession in this State, words at my command are inadequate to express to you the degree of my gratitude for your confidence, and I can only hope that my service to the Society may have been acceptable to you.

The scholarly and scientific addresses which have been delivered to you, in previous years by my predecessors, must of necessity be replaced this year by an ordinary plain talk on present day conditions and situations with which we are all more or less familiar, not with a view towards bringing forth anything new or hitherto unknown, but to emphasize certain phases of the situation which are prone to escape our attention or whose importance may easily be eclipsed by other and more brilliant affairs.

Momentous changes have taken place within the past year and a half in the attitude of the Public toward the Medical Profession; within this short period of time the Nation has declared, not in words, but in other unmistakable, irrevocable terms, that the Medical Profession is one of the greatest, most valuable assets the Country possesses in its great struggle for universal liberty.

The Nation has appealed to the trained medical man, to use his energy and knowledge for the benefit of its sons, who have gone forth to battle for the cause of liberty and civilization; and the medical man has responded nobly to the call, has offered himself willingly, at any sacrifice, even unto death; for the enemy has declared that the death of one doctor is equivalent to the death of 80 soldiers; and he has acted accordingly, as shown by his numerous deliberate, murderous assaults on anybody and anything bearing the Red Cross, the insigna of mercy and Christian charity.

The mother, who with aching heart sends her son to the front, the young wife who, bravely hiding her tears, bids her husband to go, the old man who, dispensing with the solace of his advancing years urges his son to follow the call of duty, have their anxiety lessened by the knowledge that, wherever they may be, competent medical assistance is near their dear ones should they need it.

No matter how prone the public has been in the past to show its lack of faith in the doctor, and his science, no matter how readily it would belittle him and his work and believe the fake advertisements of impostors in the healing art, no matter how little it understood the value of his services, and the fullness of his personal sacrifice, it places full confidence in him today, in the present crisis, to do his full duty, and do it well, wherever he may be placed; full confidence in him and his art to save lives and mitigate suffering; next to its God it looks to him for the safe return of its sons; and the records so far show that this confidence has not been misplaced.

These things are liable to make us vain, and we are apt to talk about being proud of our actions and achievements, proud of our position, proud of our willingness and ability to serve and in the meanwhile we are apt to forget that every other profession, industry and occupation in the land is also performing its full share of the task before us; we are apt to forget that what we have done and are doing is no more than the Nation may reasonably expect of a body of educated men and women, trained especially for service to humanity in a profession of whose foundation altruism is the corner stone. For, the higher the education of the individual, the more complete his training, the

more profound his understanding of a situation, the clearer his perception of conditions the more intense must be his sense of duty to his country and to his fellowmen, the greater must be his willingness to make any sacrifice in his power, for their welfare.

Hence it does not become us to boast of our achievements. Let us leave to others the appreciation of our services, which to us must appear only in the light of duty; let us rather consider ways and means by which our usefulness may be increased, in proportion to the growing needs of the Nation.

Let us consider that not all of us may have the privilege of serving at the front and that the civilian population at home is entitled to just as efficient service at our hands as is the soldier in the field; that the new mode of living, the extra physical and mental strain imposed upon the civilian, with their deliberating effects, calls for a greater effort, an increased energy, a higher efficiency on our part to enable us to give to the public all it might reasonably expect from us.

At this time, when the whole Nation is straining every sinew, every effort to reach and maintain a maximum of efficiency and production in every field of enterprise, it is the duty of every individual in our ranks to try to acquire and maintain the highest possible degree of personal efficiency and usefulness, and by word and example stimulate others to a similar effort; it is a solemn obligation we owe to our professional brethren who have gone to the front.

Let no one think for one moment that he has reached the acme of perfection in knowledge and efficiency, for it is a wellknown fact that some of our best men, some who ranked highest in the profession, have found, after they got into the service, that there was still something for them to learn even along the line of their own specialties.

If this is the case with the men who go to the front, may it not also be the case with the men who stay at home? providing they are given an opportunity to learn of their shortcomings and are willing to profit by it?

As a basis for improvement in our usefulness, we must study conditions as they have existed in the past, facts as they exist at present, and the possibilities and probabilities of the future.

The results of the examinations for registrants, for military service has shown that about 40 per cent of our young men between the ages of 21 and 30 are unfit for active military service; and fully 80 per cent of the defects, for which they are rejected, are due to conditions which might have been prevented by judicious treatment in their earlier life.

Who can say that the young man who is rejected for want of sufficient teeth to mastieate his food properly, has had the health supervision in his childhood to which he was entitled at the hands of his parents, his guardian, his doctor?

Who can say that the one with an enlarged heart, or a valvular disease, might not have escaped this affliction had his case of so-called "growing pains," in earlier childhood, been recognized as rheumatism, or been prevented by a judicious supervision of his mode of living and elimination of possible sources of infection, such as bad teeth, septic inflammations of nose and throat, with consequent diseased tonsils?

Who can say that the one with a chronic purulent discharge from the ear, or the one with chronic asthma or with emphysema, or what not, could not have been kept sound and well had he never been exposed to some preventable contagious disease like measles, scarlet fever, diphtheria, whooping cough and the like?

Or, that the one with marked symptoms of moderately advanced pulmonary tuberculosis, would not now be able to do his duty at the front, had his condition been recognized in its incipiency and properly treated, instead of being pronounced an ordinary "cold"?

Who can say that the one afflicted with a rigid kyphosis or scoliosis, or a deformed limb, due to a previous tuberculous lesion of bone or joint, would not now be straight and sound had he not been forced in earlier childhood to drink milk from a tuberculous cow, or been kept in company with a careless consumptive?

Or, that the weakling, undersized, underweight, lacking adequate muscular or bony development, could not now be a man of at least average physique, had he, during the period of his development, been provided with adequate food, proper dwelling and proper physical exercise?

Who *can* say? In the face of the findings and results of latter day investigations and experiments who *dares* say?

Now comes the question: Who is to blame for these deplorable facts? No one at present; for

they are the result of conditions which existed during a period in the lives of these unfortunates when adequate preventive measures only, judiciously applied, could have made a difference in the status of their present health; conditions which by their very nature prevented the application of such measures. At that time the great mass of the people did not know the value of preventive measures against disease and the doctors who did know, or at least were supposed to know, were powerless to apply them.

But, conditions have changed; the appreciation of the value of hygiene and preventive health measures is rapidly becoming universal; the time is coming without fail, and is coming soon, when the public will hold the medical profession of today responsible, and rightly so, for the physical condition of the coming generation.

Let us not wait until the people blame us for illness and deformity because we have not done our utmost to prevent them. Let us not wait until the public holds us responsible for its own ignorance, in health matters because we have neglected to enlighten it on the subject. Let us not wait until the community demands that we give it the benefit of our knowledge but let us begin now, while we have the best opportunity that has ever presented itself, the opportunity to demonstrate to the understanding of everyone, how the growing child will finally become either an asset or a liability to the community, to the State, to the Nation in proportion to the health supervision it has received.

It is the duty of every member of the Medical Profession to constitute himself, or herself as the case may be, a special supervisor of the health conditions in the locality in which he or she resides; to co-operate with existing health organizations in the detection and elimination of unsanitary conditions which create and promote the spread of disease; and, where no public health organizations exist, to use most strenuous efforts to have them established, and in connection with them, easily accessible public or private laboratories, as scientific aids in diagnosis and therapeutics; that science and art may go hand in hand in our work.

We should influence those in authority to provide ways and means to have every child examined for possible remediable defects and to have these defects corrected, that the child may have a chance to grow up to useful, physically perfect manhood or womanhood.

It is our duty to have sanitation and hygiene effectively taught in the schools and brought to the notice of the parents for the benefit of the child; to have a competent and thorough inspection made of all food supplies, especially milk and water; and to urge the elimination of all disease carriers, such as rats, mice, mosquitoes, flies and other vermin, by a systematic thorough cleaning up and keeping clean of all dwellings and surrounding premises.

Up to within recent years it has been considered the only duty of the Medical Profession to mitigate suffering and assist the natural forces of the human body to resist and overcome disease; but present day developments have shown that our supreme duty is the prevention of disease, and this should be our highest aim; while we must not neglect to administer to the grown up in his illness to the best of our ability, we must not forget that we are not doing our full duty to our Country if we are not working with all our might, heart and soul, for the welfare of the coming generation—the child of today.

In the meanwhile let us not lose sight of our obligation to our own individual patients.

When a patient comes to our office and we prescribe for him, or give him medicine for a so-called "cold," and neglect to give him a thorough physical examination to find the true underlying cause of his ailment, both the predisposing and the exciting cause, aside from the supposed "draft," or exposure to night air, mentioned by him; if we neglect, in addition, to make a thorough examination of the ears, nose and throat, so often the seat of primary infection which may be the underlying cause of some obstinate chronic disease; or of the teeth, the primary essentials to a good digestion and assimilation; or of the eyes, many times the cause of repeated headaches and other, sometimes grave, nervous manifestations; if we are not making use of all modern methods of aids to diagnosis, chemical bacteriological, pathological and X-ray laboratories, as the case may require, we are not fulfilling our obligation to our patient, we are not sustaining the reputation of Medicine.

But, you will say, it is impossible for any one man to do that with every one of his patients. Certainly it is. No one man can be an expert in

all the various branches of Medicine and Surgery and the collateral sciences. Medical science has made such rapid progress of late that it is utterly impossible for any one man to master it all; it therefore becomes absolutely necessary that a number of specialists co-operate in a given case in order to reach a definite and correct conclusion.

This brings us to a favorable consideration of the suggestion so ably presented last year, by Dr. Dearholt, in his presidential address to this Society; the idea of team work; a combination of physicians into selected and well balanced groups.

The wonderful achievements of the Medical Service in the Army and Navy today, is due to just such team work. Every one of the 30,000 medical men in the United States who have given up their private practice to become the Nation's Medical Reserve, has lost his identity, his individuality and has become one of a group of co-workers either at camp or at base hospital service. There is no Dr. Jones there, no Surgeon Smith or Specialist Brown; they have given way to and have become a part of "the Medical Force of the Army"; one body, with one activity and only one aim, and that the efficiency of the fighting force.

As one captain expressed it to me: "It's a glorious fact that no feeling of competition exists in the Medical Force of the Army; consultations are as common there as they are unique in private practice.

The so-called "paper work," the system of history taking and record keeping is wonderful and complete. No decision is made in any case without a consideration of the combined findings of all the members of the group, specialists in every branch of the science, including chemistry, pathology, bacteriology and Roentgenology.

If such team work is considered essential for the efficiency of the army medical service, is it not also essential for the efficiency of medical service to the civilian population?

The old axiom: "united we stand, divided we fall," is applicable to the medical profession as much if not more so than to any other profession or enterprise in which men may engage. In order that we may become a power for greater good, a real asset to the Nation, capable of fulfilling our duty to humanity, a closer co-operation of all the members of the profession is essential.

Woe to the man or woman who for either personal, selfish, or pecuniary reasons neglects to see this obligation to mankind.

The thought, whether the public will ever fully realize our aim, and show its appreciation of our altruistic efforts, or whether it will continue to deprecate our achievements by listening to the blatent cry of the charlatan, shall not and will not swerve us one iota from our path of duty. However, it is hardly reasonable to suppose that an intelligent public would not eventually recognize true worth and place the credit where it belongs, when it considers the work that the medical profession, and the medical profession only, is today called upon to do and is capable of doing; a task which no self-styled healing method could possibly accomplish.

One of the means by which an increased efficiency for the benefit of the Nation can be acquired on our part, is an active membership in our County and State Medical Societies; an active membership, not merely a nominal one. This becomes obvious when we study the means by which all advancements in Medicine and Surgery have been achieved and become promulgated.

All scientific discoveries and progress have had their origin in the mind or the activity of some individual, and have been disclosed to others, for the benefit of mankind, primarily in the discussions at some meeting of some society.

The rapid advance Medicine has made within the past century, both as a science and an art, was possible only by virtue of the concurrent organization of national, state, district, and county medical societies, where new theories, new remedies, new methods of treatment were presented and discussed.

The county or local medical society is the primary field for the dissemination of practical medical knowledge; a so-called experience meeting in a medical society, where everyone is willing to disclose, for the benefit of others, his observations, the knowledge he has acquired in the use of certain remedies or manner of treatment, where every one is willing to discuss and profit by the experience of others, is worth more to the profession and to the public in that locality than any other form of post-graduate work.

No one, who has ordinary power of observation and reasoning, can have practiced medicine for any length of time without having acquired some

knowledge which is not generally current, and which would be of use to his fellow practitioners.

No one can be so highly educated, or have so much experience, that it would be impracticable for him to acquire more knowledge through the experience of others. The physician who says he can get nothing worth while out of a society meeting either has nothing to give or is not willing to give anything. The benefit derived from any organization or institution is in direct proportion to the service we are willing to render it; in other words, we get out of our society just what we are willing to put into it.

In addition to discussions of scientific and practical subjects, the program of each county medical society should make provision for some social hours, and not a few of them; gatherings where members of the medical profession will meet as men, not as doctors; where informal talks on any subject may be had.

It is there where we can discover the true value of our brother practitioner and learn to appreciate him; where true fraternal spirit is created and enhanced, where the sentiment of a more intimate brotherhood in the sublime service to mankind is stimulated.

It is there where the "competitor" in our field of labor will finally be eradicated and be replaced by the "colaborator," the brother practitioner; where is verified the truth of the old saying:

There is so much good in the worst of us,
There is so much bad in the best of us,
It little behooves any of us
To find fault with the rest of us.

Active membership in our County and State Medical Society is an asset without which it is not advisable for us to carry on our work; for it is only by a close intimate association with our professional brethren that we can acquire broader views and a more liberal education in our chosen profession.

It is a duty we owe to ourselves, to the public, to the Nation, for it enables us to appreciate our own limitations, to acquire more knowledge and increase our efficiency.

It is a privilege, for it raises our standing in the esteem of our confreres as well as of the public. Find the man or woman who always has time to attend the meetings of his or her medical society and you have the one who stands highest in the profession in that locality, highest in the esteem of the public.

You may say that this talk does not concern us, who always attend all the meetings we can possibly attend; these remarks might be of value to so-called slackers in our profession.

Ladies and gentlemen, this talk, if logical at all, should concern us as well as any one else; if the contentions set forth herein are correct, it imposes upon us who regularly do attend the meetings of the various societies of which we may be members, be they medical, fraternal, civic or political; who have learned the value of and the benefits derived from these meetings, a duty from which our own position does not release us but, on the contrary, makes more imperative, the duty to hold meetings oftener, to make them interesting and instructive, to use our best efforts to bring those who are negligent in their attendance to a realization of the opportunities for betterment which they are missing, to an appreciation of their obligation to the profession, the duty they owe to themselves, their families, their patients, to the public at large.

For, it is to just such bodies of men and women as are represented here, active members of county, state and national medical and other societies, men and women of intelligence, honor and integrity, imbued with unselfish devotion to the welfare of mankind, alert to the needs of the nation, replete with loyalty to their country, that the world must look for the maintenance of American liberty.

I thank you.

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On one day in June approximately 27,000,000 cartridges of various descriptions were produced in the United States manufacturing plants for the United States Government.

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The Ordnance Department has produced 2,014,815,584 cartridges, 1,886,769 rifles, and 82,540 machine guns since the United States entered the war. The daily output of cartridges is now 15,000,000.

MENTAL DEFICIENCY.*

BY JAMES F. McFADDEN, M. D., (St. Louis, Mo.),
CAPT. M. C. U. S. A.,
JEFFERSON BARRACKS, MO.

The problem that we are to consider this evening is a most serious and important one. It has many interesting angles, the study of each of which would consume many hours, to say the least. With this in mind, it behooves us to apply the very limited time which has been allotted for this paper solely to the one which is most vital from a military viewpoint. The subject at hand is that of Mental Deficiency and its military aspects. Literally, the term mental deficiency, to use the words of Tredgold, "is just as applicable to a decay as to a non-development of the mental powers, to the dotage of old age, or disease, as to idiocy from birth, and is still often used indiscriminately of either of these conditions." There is, however, a great difference between them. He compares mental defect occurring subsequently to mental development, to a state of bankruptcy, while on the other hand he considers the one whose mind has never attained normal development similar to one who has never had a bank account. To the former is given the name, dementia, while the latter may be known as amentia. In this paper we shall consider mental deficiency as meaning amentia, and leave dementia to come under the heading of psychoses.

Then, mental deficiency is the state of mind in which the mind has failed to reach normal development. One may now ask, "What is normal development?" The normal may vary within a wide range, but a good definition may be, "That degree of intellectual capacity sufficient to enable one to perform his duties as a member of society in that position of life to which he is born." Perhaps, at this writing and under the existing circumstances, for our own use, it will be permissible to change this definition somewhat, and cause it to read, "That degree of intellectual capacity sufficient to enable one to perform his duties as a soldier in this world conflict."

ETIOLOGY.

The causes of mental deficiency are varied, but it usually has its origin in a defective heredity. It is true, however, that accidents and injuries before, during and after birth may cause an arrested cerebral development. Syphilis has been considered a very potent factor, but Goddard says, "There is little evidence that syphilis is a cause of feeble-mindedness, as these cases are very largely in the hereditary group." Alcoholism of the parents has often been referred to as a source of great degeneracy in the offspring, but many reliable observers at the present time are taking a different view of the situation. A large proportion of alcoholics are found to be mentally defective, or extremely neurotic, and their offspring but an expression of their own inherited taint, rather than a product of their parent's drunkenness. Goddard holds that every feeble-minded person is a potential drunkard, and is bound to be the victim of his environment, and that the number of persons in whom alcohol has produced a weakness of the will is comparatively small. Although it is a popular belief that consanguinity of parents brings feeble-minded offspring, statistics do not bear it out; but given a tainted family, the matings of two members of the same family increases the liability of the defect appearing.

CLASSIFICATION.

Within the past few years, much work has been done to define as accurately as possible the relative grades of defect. This has resolved itself into an attempt to correlate the psychological development of the defective with the psychological development of the average child, thus considering age of a psychological, rather than of a chronological, significance. As a result of this classification, we may speak of a man thirty-five years of age, as having a psychological age of seven or eight, meaning that he has the mental development equivalent to that found in the average child of seven or eight years.

Probably the best tests we have at the present time are the Binet-Simon Tests, and the more recent Point scale of Yerkes and Bridges. Binet-Simon, after studying a large number of school children with various tests, formulated groups of tests, each group representing a year in development. They gathered a group of questions and tests which, according to their experiments, any child of three years could answer correctly, but one of two years could not. Another group could be answered by a child of four, and not by one of

*Read before the Post Medical Society, Jefferson Barracks, Mo.

three. Another set which a child of five could pass, but one of four would be unable to do so; and so on for each year up to twelve years. This set of tests proved of great value in classifying the feeble-minded.

Yerkes and Bridges, seeing that unless the patient answered the question correctly he received no credit for having it partly correct, and in some cases this would cause him to come lower in the scale than he really should. They also wished to get a set of tests which could determine the mental age in a shorter time. With this end in view, they formulated the Point scale, which test can be made within a comparatively short time. It also goes above twelve years. This test is of great value in picking out those who should be observed and have a more extensive examination. The same set of questions are asked of everyone. Credit is given on all answers according to the degree of correctness. The percentage is computed and compared with the percentage the average person of that age should make.

The classification according to Binet-Simon has recently been adopted by the American Association for the Study of the Feeble-Minded. This places these cases into three psychological groups, viz.: idiot, imbecile and moron.

1st. The idiots, those showing a complete absence and an impossibility of fixing attention. These individuals never develop in mind beyond the level of a three year old child. They are perfectly helpless, absolutely incapable of looking after their wants, or of protecting themselves from harm. They have to be cared for in institutions.

2nd. The imbecile, showing some powers of voluntary attention, some degree of learning capacity, but attention is quite unstable, and they never develop in mental capacity beyond the level of a seven year old child. They are capable of protecting themselves from danger, but not able to earn a livelihood, so that they also have to be cared for in institutions.

3rd. We come to the higher grades of feeble-mindedness, the morons. These individuals range in mentality between the ages of eight and twelve years. They never develop in mental capacity beyond the level of a twelve year old child. Their powers of attention are unstable. All their psychic processes, though considerably superior to the idiots and imbeciles, are nevertheless defective, sluggish and lacking in variety, entailing insufficiency in judgment and absence or rarity of generalized ideas. Their memory is poor, their learning capacity substandard and defective. Unable to profit by experience as the normal individual does, they are far more liable to repeat the same act, though a criminal and harmful one, over and over. They are perfectly capable of protecting themselves from harm and of earning a livelihood, but are lacking in the higher mental faculties of judgment, reasoning capacity, self-control, etc., that guide one's conduct along normal lines. Remaining children in mentality even after becoming adults in physical years, they naturally are never able to understand and measure up to the dictum of society. From the nature of their own non-development they fail to grasp their obligations to the order of society, and consequently fail to obey its mandates. They become more easily entangled in the meshes of crime, simply because of their stupidity, and when at large drift into prisons, almshouses, hospitals and other institutions. They wander from one position to another, incapable of sticking to any. No wonder that we find them endeavoring to get ahead by acts that are of anti-social nature, for they are unable to fight the battles of life as their more normal brothers and sisters. With their poorly working minds, they more easily drift into criminality, prostitution, chronic alcoholism, etc.

DIAGNOSIS.

It must be granted that the above mentioned tests are not entirely satisfactory, yet, a fairly accurate mental status can be reached by a trained observer, and in our present work a great deal must depend upon the judgment of the examiner. The general make-up of the individual must be considered as well as his reactions to social problems during his past life, his ability or inability to obtain and retain remunerative employment, history of delinquencies, and in fact, we find that here, as in all other departments of psychiatric work, a complete history is highly essential.

PROGNOSIS.

The final outcome of these cases must be thoroughly considered, for the minds of the combatants in this great struggle are being, and will continue to be constantly subjected to a much greater strain than that met with in civil life; in fact, to the greatest strain ever placed upon them. The

soldier of today must form the habit of thinking quickly and to the point, and to act with promptitude and fortitude. Considering these facts, there is little wonder that we are compelled to return a grave prognosis for these unfortunate individuals. As all of this class are potential military, civil and moral offenders, it is logical to assume that they will sooner or later find themselves in military prisons, charged with offenses for which they are not responsible.

In the very nature of their own non-development they see and understand things from an abnormal point of view. What happens in the majority of defectives? They are likely to become hopeless perverts. At least the mental arrest becomes so firmly fixed that all possible chance for improvement is entirely destroyed; if in fact any such possibility ever existed. Not only this, but there is a chance for some advance along the lines of habit training, which too is lost because of the continued failure to classify correctly the conditions. We have but to analyze the individual makeup of our penal and reformatory population to find an alarming percentage of mental defectives, as well as epilepsies, insanities and all the various subnormalities and abnormalities of the human mind.

DISPOSITION.

In civil communities the disposition of the feeble-minded has always been a very serious problem, but in the army, it consists mainly in diagnosing and eliminating them from our ranks, for their potentialities are such that their presence would undermine the efficiency of our fighting machine. Our duties at this depot are primarily the recruiting of mentally and physically fit men for military service, and the elimination of the unfit, returning them to their civil communities which must necessarily assume the responsibility of solving the social problem of their disposition. Undoubtedly, during our reconstruction period, these same individuals will again come to our attention, and it is then that we will have to face the problem from a different angle, and attempt to formulate more definite plans for their care and training.

It is of the utmost importance that we distinguish carefully between crime and mental deficiency. We could hardly consider the countless thousands of mentally weak and varying degrees of abnormality, who are incapable of understanding and measuring up to the demands of society, as criminals. They are defectives and should be classified and treated as such.

Quite frequently society looks upon the various degrees of mental deficiency as crime. The feeble-minded individuals fail to understand their obligations to the order of society, and because of their failure to obey society's mandates, they are arrested and committed to some prison or reformatory and are as much out of place there as out in society.

In conclusion, we should all consider it our duty to watch for these cases as well as for those with physical defects, and whenever necessary have them rejected or discharged from service, for in so doing we are not only upholding the standard and rendering more efficient the army we have sworn to uphold, but we are also rendering a service which is due to the individual himself.

THE UBIQUITOUS ANAEROBE.

BY W. E. BANNEN, M. D., AND A. A. SKEMP, M. D.,

LA CROSSE.

On July 2nd, J. H. was kicked by a colt and sustained a bruised thigh and calf and a dislocation inward of patella. The dislocation was readily reduced. There was no break in the skin but there was complete loss of function from knee down and loss of sensation. Life returned gradually to the part with the subsidence of swelling and after ten days the line of anesthesia became fixed at the level of ankle. July 14th a red spot of a few centimeters diameter appeared on dorsum of foot, grew gradually, and the pain in leg became intense. Family physician and consultant came shortly after and found that the foot was completely anesthetic and that a two inch needle could be plunged into it to its depth and elicit no pain.

Entered hospital July 16. Note at that time: Foot cold, bluish cadaveric discoloration, anesthesia complete. X-Ray of leg and foot negative. Diagnosis of traumatic thrombosis with failure of collaterals made, and demarcating line awaited before amputation.

The patient spent a most restless night, but not until the night of July 17 did the unrelenting pain begin. Because of the intense pain, operation de-

cided upon. In shaving the leg the orderly detected very slight crepitation. This confirmed on the operating table and it seemed that there was no explanation other than gas bacillus infection. An immense bleb covered practically the entire dorsum of foot and the bluish cadaveric discoloration of foot had spread up over leg, though the swelling was very slight.

Amputation done by aperiosteal method above the knee joint, a large needle attached to the oxygen tank and the stump thoroughly infiltrated with oxygen before the flaps were brought over. Dry dressing applied.

Temperature went up the following day and the flaps became crepitant. They were removed in toto and ogygen was injected into the muscular tissues of the thigh as far as gluteal region. Sodium perborate solution 5% used as irrigant for two days, with the hope that the oxygen liberated would combat the anaerobic conditions. Continuous Dakin's irrigation then started over stump; the wound became clean after a week's treatment and when the granulations became fit the area was covered with skin grafts. The convalescence was practically complete by Aug. 12th.

Material from the bleb was injected into rabbit shortly after the animal was chloroformed. Within three hours the animal was distended and the following morning it was ballooned up, crepitant and odoriferous, confirming the suspicions of gas bacillus infection. An X-Ray of the leg showed the open air spaces that the war radiographers describe as characteristic of bacillus Welchii infection. The case was instructive from several angles. Briefly it reiterated the importance of eternal vigilance on the part of every one attached to a hospital; it emphasized the necessity of facing issues which may appear illogical or impossible even though they look us squarely in the face, for it must be confessed that the case was puzzling because we had a perfectly intact skin and no possibility of anaerobic conditions was present until in reviewing the history it was recalled that a big pin had been buried in the foot in several different places. Perhaps even the "aseptic conscience" was suggested by the story and maybe too the Golden Rule.

Your patriotic duty is in proportion to the money you earn. The more you get the more you can, and should, invest in War Savings Stamps.

BECK'S BISMUTH PASTE IN THE TREATMENT OF CERVICITIS, ENDOCERVICITIS AND ENDOMETRITIS.

BY A. R. HOLLENDER, M. D.,

LINDEN.

A few years ago, while associated with Dr. Emil G. Beck of Chicago, I was greatly impressed with the method he employed in the treatment of cervicitis, endocervicitis and endometritis.

The simplicity of the method and the results which I observed from the treatment in a large number of cases, a good many of them having been under my personal supervision, have induced me to employ the paste in my practice for the treatment of cervical disease. My report is based on a series of fifty cases from my own practice and no less than three hundred from Dr. Beck's. I shall mention the points of technique that have made this method a success, but desire especially to call attention to the possible dangers if the method is used indiscriminately.

It is well established now that most cases of chronic discharge, commonly called *leucorrhea,* or the *whites,* result from infection or disease of the cervical canal. Only in a small percentage of cases is there infection of the mucous membrane of the uterine cavity. In many instances, the uterus does not suffer at all, and the vaginal discharge which is present is due to an inflammatory change of the vaginal mucous membrane.

We have been accustomed to treat these cases by the application of Icthyol tampons. In a large majority of patients after a long drawn-out course of treatment, improvement followed. If on the other hand, the tampon applications were ineffective, curettage was advised.

If we look back to analyze the good results obtained from curettage, most of us will be sadly disappointed. The improvement in most instances is only temporary, and often the symptoms are greatly aggravated. Fifteen or twenty years ago, curettage was an operation commonly performed in the absence of something more satisfactory, but today, among the more modern men, it has fallen into disrepute. This statement is confirmed when we look over hospital bulletins, as it is infrequent that we find this operation posted.

Dr. Beck's method as I have employed it during the past year is as follows: In cases in which

there is an erosion of the cervix, forty per cent silver nitrate solution is applied to the erosion and into the cervical canal by means of a small cotton applicator. Immediately thereafter, about one drachm of bismuth paste (a mixture of ten per cent bismuth subnitrate and ninety per cent vaseline) is injected into the cervical canal by means of a glass uterine syringe. The paste must not be in a liquid state as is used for injecting suppurative sinuses in other parts of the body. It must be *cold*. In this way the uterine cavity is filled out with the paste, but in so doing the greatest care must be exercised that the paste does not enter the Fallopian tubes. This can be prevented if the operator is exceedingly careful and uses very gentle force. The applications are repeated either daily or every second day, and in some cases two injections weekly will suffice. After the injection a cotton tampon is packed against the cervix for obvious reasons. As a rule the creamy-pus discharge will change into a clear mucus after a few treatments. In those cases in which the discharge is muco-purulent, it will persist a little longer, but a gradual improvement is sure to be observed in practically all cases. In reviewing Dr. Beck's records, I found that about eighty per cent of his cases ceased discharging after receiving the treatment for a period of from one to six weeks. The remainder did not cease entirely, but in all there was considerable improvement. The results in my own series of fifty cases were to some degree even better. I was able to arrest the discharge in ninety per cent of the cases with from three to ten injections. Of the other ten per cent two suffered no further symptoms after the first injection, while two failed to appear for the full course of treatment. One case persisted in discharging in a gradually diminishing amount until nineteen injections had been given, when the discharge finally ceased. This was a case of chronic cervicitis of twelve years standing which had become so severe as to produce symptoms of hysteria. After the cervical infection had been cured, the nervous symptoms disappeared. It will thus be understood that the method has been given a thorough test and has proved efficient in over three hundred and fifty cases. Bismuth paste may truly be considered a specific for the eradication of cervical disease.

It should be mentioned, however, that, now and then, a case will appear in which the old trouble has recurred. I have not had to contend with these, although I am prepared for such a contingency. I recall a very few who returned with the complaint while I was carrying out this treatment for Dr. Beck. In such instances where there is recurrence, the symptoms are very mild and hardly noticeable, and after the resumption of the treatment for a week or two, no further trouble is encountered. Many times, patients will not return for treatment after the discharge has been arrested, thinking that they are cured, and we have come to the conclusion that it is these cases in which recurrence is likely to exist because of insufficient treatment. As a rule, a case is never discharged as cured until smears and cultures prove the uterine discharge normally sterile.

Occasionally I meet cases which I believe are unsuited to this method—or those in whom there is even a very slight danger of forcing the paste into the fundus or deeper. For this class of cases, I use a bismuth paste gauze, simply a strip of uterine gauze saturated with the paste, and pack this into the cervix with one end projecting out of the vagina, and held in place by a vaginal tampon. The patient is instructed to pull this packing out within twenty-four hours and follow with a warm douche.

For vaginal leucorrhea I have yet to meet a better treatment than the packing of the vagina with bismuth paste gauze. This I do twice weekly, the patient using a douche after removing the packing.

My experience has taught me that douches in themselves will never cure a case of cervicitis or vaginal leucorrhea. I have in the past used various forms of medication for swabbing the vagina, and while some of these have proved efficacious in many instances, they are unsatisfactory.

I have always wondered why Dr. Beck had not published the results he has had in treating cervicitis and endometritis. And it was not until I put the question to him that I learned his attitude on the subject. He thought as I do, that the method is not entirely without danger. Undue force in injecting the paste into the cervix, may be the cause of forcing some of the pus within the tubes into the peritoneal space. The result would be a peritonitis. The promiscuous use of the method, especially in the hands of the novice, would thus be the cause of much trouble, and would render it a harmful procedure. In the hands of one who gives this subject some degree of

study with the consideration that it should have, and with the proper selection of the case, the treatment is almost certain to be a success, and is without danger if the points of technique are carried out as has already been described.

Dr. Beck's opinion on this written to me recently is as follows: "I was afraid that the general practitioner all over the country might use the method indiscriminately and produce a great deal of harm. There are several millions of women in this country who have so-called leucorrhea. A great number of these could be cured if this method could be applied by those who have had experience with it, but imagine if the practitioner who has not the proper instruments would use an unsterilized syringe with a long nozzle and some three or four ounces of the paste, without much thought of the after results. For this reason the matter must be handled with great care and caution."

TRAUMATISM A FACTOR IN THE ETIOLOGY OF PANCREATIC CYSTS.

BY R. W. JONES, M. D., F. A. C. S.,

WAUSAU.

In looking over the literature of Pancreatic Cysts, one is impressed with the apparent rarity of such cases. I have been able to find 196 cases recorded. I feel that this condition occurs much more frequently than these statistics indicate and believe the cases are not reported or if reported, are buried in society proceedings. Cysts of the Pancreas occur as (1) Retention Cysts. (2) Proliferation Cysts. (3) Pseudo Cysts.

Retention Cysts, as the name would imply, are caused by obstruction to the outflow of the products of the gland within or without the gland or duct such as (1) Chronic indurative neoplasm of the Pancreas. (2) Pressure from Gallstones. (3) Pressure from growths of neighboring organs. (4) Chronic Pancreatitis, causing a roseolaous dilatation of the duct. (5) The presence of a stone in duct of Wersung. Anyone of these and many other conditions, may cause a retention of the gland product and Cyst formation. These Cysts may be single or multiple, may or may not be lined with epithelium, and may or may not contain the pancreatic ferments, depending upon the amount of pressure in the Cyst and the age of the lesion. Traumatism very frequently seems to be the initial factor in the etiology of these retention Cysts, probably because trama may crush the duct or a portion of the gland causing obstruction.

The proliferation Cysts are to be regarded as new growths, the most common variety being the adenocystomata; these presumably occur more frequently in females, they develop slowly, only symptoms being those of digestive disturbances until by nature of their size they cause symptoms of pressure. If these Cysts are seen while still small, they can be differentiated, because of the thin connective tissue and epithelial proliferations into the Cyst, but if some time has elapsed and the Cyst has attained some size, the pressure of the Cyst contents may obliterate and absorb these proliferative features. The malignant growths usually develop in this variety. Traumatism as a causative etiological factor has never been mentioned in the cases reported.

The third variety or Pseudo Cysts, is the most commonly seen, it is frequently impossible to state whether a Cyst is true or false. The diagnostic importance of the pancreatic ferments in the contents of the Cyst is questionable. False Cysts—accumulations of fluid in the lesser peritoneal cavity from an old hemorrhage may contain pancreatic ferments, and where the traumatism occurred very close to the pancreas, may even have a portion of pancreatic tissue in the lining of the cyst; while true cysts may lose both epithelial lining and pancreatic ferments because of pressure of the cysts contents and digestion of its ferments. In this class of cysts, injury plays a very important etiological role—the patient usually gives a history of compression of the upper abdomen by some large object; pinched between railroad cars, caught under an overturned wagon, squeezed by a horse, etc., these are some of the ways in which the traumatism was received in reported cases. The patient is incapacitated for a few days, but after ten to twelve days gets back to work. Just what happens it is impossible to say, whether these large cysts are accumulated gland secretion from an acute pancreatitis caused by traumatism, or the end products of a hemorrhage, it is impossible to state, but it is quite evident that injury in some way seems to be a leading factor in their origin. After varying lapses of time the patient complains of pain in the abdomen, usually sharp cutting pains, lasting but a short time, but recurring more

often as time elapses. He complains of various symptoms of indigestion. Later he notices a tumor mass which grows steadily and causes various pressure symptoms.

Pancreatic Cysts in their growth are quite characteristic, according to the portion of the gland from which they grow; they may present themselves in this order of frequency: (1) Between the stomach and trans-colon, the stomach being pushed upward and to the right. (2) The cyst may displace the stomach downward pointing above in the gastrohepatic omentum. (3) The cyst may push its way forward between the layers of the transmesocolon.

The clinical diagnosis depends upon (1) the history of the case. The patient should be thoroughly questioned as to the existence of any previous injury as the factor of traumatism seems to be of great etiological importance in the Pseudo Cysts and Retention Cysts. Examination of the literature of the subject would tend to bear out this belief, as over 40 per cent of the cases of these two varieties of cysts reported, mention trauma in their history. Lazarus in his experimental work, demonstrated the formation of a cyst secondary to a pancreatitis, which originated in traumatism.

The symptoms will vary with the cause of the cyst; if Chronic Pancreatitis, the patient will complain of dyspepsia, loss of weight and epigastric pain. Soon the patient notices the presence of a palpable tumor mass which does not move with respiration, of varying rapidity of growth depending upon whether or not hemorrhage occurs into the cyst. The cyst in its growth will follow distinct lines as had been pointed out, and its relations with the stomach and transverse colon will conform to one of the three lines of growth.

Treatment consists in evacuation of the cyst with or without removal of the cyst wall; ordinarily the cyst wall will be so adherent as to render the removal hazardous and marsupialization of the cyst, in most instances, is sufficient for cure. The Pseudo Cyst, which occurs most commonly, often grows to quite considerable size; the fluid filling the lesser peritoneal cavity, and pushing forward causes marked pressure upon the stomach and colon. In evacuating the contents, it is advisable to anchor the cyst to the abdominal wall, to prevent the escape of contents into the abdomen with possible consequent digestion of the tissues.

L. G., age 18, laborer, referred by Dr. N———. Family and previous history negative. Five months ago patient was caught by an overturned wagon, severely compressing the upper abdomen between the wagonbox and the ground. When the weight was removed he was taken to a hospital and stayed there two days, but claims he felt well and had no pain at any time. Three weeks after the injury the patient noticed a mass forming in the abdomen, in the center and slightly to the left of the median line. This mass has grown steadily until now the abdomen is enormously distended. At the present time the patient is unable to retain anything in his stomach, vomiting shortly after the ingestion of food. The mass is not sensitive and the patient has no pain.

Physical examination—The apex beat seems displaced outward and upward; the abdomen is greatly distended by a mass palpable in the upper abdomen. The mass feels cystic, is movable sideways, but not upward or downward, more on the left side of median line than the right, extends upward under left costal margin. Blood, urine, stomach and stool analyses, negative. Bismuth meal pictures show the stomach pushed off to the right and upward, very small in size. The transcolon lies below the growth which apparently presents itself to the gastro colic omentum. Diagnosis of Pancreatic Cyst was made and operation advised.

March 16, 1915, the abdomen was opened under ether anesthesia. At once after going through the peritoneum, this large mass presented itself with markedly enlarged gastro colic vessels. Incision was made through both layers of the great omentum and the post layer of the peritoneum. The cyst was drained of about eight quarts of fluid; the opening was enlarged enough to admit the hand and the pancreas palpated. The cyst seemed to originate near the head, and the pancreas seemed to lie either in connection with or in close contiguity to the cyst wall. The opening to the cyst was secured to the abdominal wall and drainage tubes with light packing, left in for a few days. There was some little fat digestion along the edges of the wound, but the discharge rapidly became small in amount, the wound healed and the patient was discharged April 10, 1915, in good condition.

The fluid which was removed was thin, watery in consistency with numerous flocculi resembling fat, there was no evidence of blood in the fluid, but laboratory analysis showed the presence of trysin.

March 1, 1917, the patient was examined and seems in perfect health, he complains of no inconvenience of any kind and examination of urine for sugar is negative.

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ABSTRACTS

ENURESIS. J. I. Grover, Boston (*Journal A. M. A.*, Aug. 24, 1918), reports observations on about 200 cases of bedwetting for over seven months, all in children under 12 years old. Sixty-two per cent. were boys, and in most cases there was a family history of similar conditions. In 59 per cent the wetting took place only at night, and in 68 per cent it occurred every night, the remainder less frequently. Seventy-nine per cent had always wet the bed from babyhood; 20 per cent began later in life after a normal period. Fifty-one per cent of the boys had previously been circumcised without good result as regards this condition, and 36 per cent had had adenoids removed without apparent relief. In two cases they were made worse. Only two patients were feeble-minded, and four had some external genital abnormality. There were many accompanying conditions present, among the more frequent being pinworms in thirty-four cases, pyelitis in eleven, tuberculosis in five, chorea in four, orthostatic albuminuria in four, adherent prepuee in four, and thirteen other conditions, such as would be met with in any ordinary clinic. Enuresis is probably never a disease entity, says Grover, but simply a symptom or evidence of an underlying cause, namely, a neuromuscular fatigue. It is not localized but general, and is a chronic condition. The patients are active and nervous and sleep soundly, waking with difficulty. The author believes that it is a similar neuromuscular fatigue that makes some children stutter and others have habit spasms. Mental strain is often a factor. Many of his patients attended parochial schools that exacted almost seven consecutive hours of work, besides two or three hours doing home lessons at night. Diet is another important factor. It was very poor in 95 per cent of the cases. The patients were getting plenty of food, but it was not the kind needed. Indigestion was uncommon, but the gastro-intestinal tract was constantly under strain. Besides the general underlying cause of neuromuscular fatigue, habit must be reckoned with, and Grover compares the cause and habit in enuresis to it as being due sometimes to the cause and habit in whooping cough. The size of the bladder must also be considered. It is never fully distended in the congenital cases and this must be treated. The treatment given was altogether on dietary and hygienic lines. The diet was regulated and all food was forbidden between meals. The selected diet list included milk, eggs, butter, meat, fish, bread stuffs, cooked cereals, macaroni, vegetables, oranges, stewed fruits, and simple, unsweetened desserts. Soups, coffee, cream, candy, pastry, highly seasoned foods, etc., were forbidden. The child was required to be in bed at 7 p. m., and in very nervous cases school was temporarily prohibited and a nap required at noon. No play was allowed after 4 p. m., but the child could entertain himself by books or toys in a chair. Moving picture shows, music lessons and home lessons were prohibited. The habit element was treated in the usual way. No fluids were allowed after 4 p. m., and there were regular hours for urination at night, punctuality being required. The day wetters were made to urinate at regular stated times, anywhere from every three hours down to every twenty minutes. Nineteen per cent of 131 cases ceased the habit after their first visit for instructions, and another 23 per cent were cured within a few weeks or months. An additional 31 per cent were reduced in number of wettings to once a week or so, and 13.5 per cent were partially relieved. Sixteen per cent were not relieved at all. Many of the other coexisting disorders were markedly improved, such as habit spasm, stuttering, petit mal in one case and almost all recognized an improvement in their irritability and gained weight, though there was often an initial loss at the beginning of the treatment. It is common knowledge that mild cystitis and pyelitis are secondary conditions flaring up when the patient is run down or diseased. The general body fatigue may be responsible for both. On the same theory atropin, strychnin, or thyroid may act as nerve or muscle tonics. It is usually conceded that drugs without proper hygienic treatment have little effect. As the children were all outpatients and the treatment carried out at their homes, perfect success could hardly be expected but the paper is offered as showing the effect of simple, regular diet, rest and little or no excitement in these cases.

We expect, as a matter of course, that our soldiers and sailors will do as they are ordered. We oftentimes do not think it necessary to do what our Government asks us to do. Why should we not be just as prompt in our response? Our men are ordered to expose themselves to the guns of the Huns. We are asked only to save and to loan our savings to the Government. Can we refuse this request?

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ROCK SLEYSTER, M. D., Editor
Waupun

J. P. McMAHON, M. D., Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:
A. J. PATEK, M. D., Milwaukee
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EDITORIALS

A FIVE MILLION ARMY MEANS FIFTY THOUSAND MEDICAL OFFICERS.

WITH an army of three million men in the field or in training and as contemplated, an expansion of this force to five million men, the Surgeon General must have in the Medical Reserve Corps at least fifty thousand doctors.

The Medical Corps must keep a pace in growth with the army expansion and it behooves every doctor in the United States between the ages of 21 and 55, who is physically, morally and professionally fitted, to arrange at the earliest possible moment, his personal affairs so as to offer his services to his country in the capacity of a medical officer.

The United States is in the war to do her part in winning the struggle and this can only be accomplished by a large and well trained body of troops adequately cared for by sufficient number of medical officers. The importance of the doctor's service and its relation to the successful outcome of the war cannot be under-estimated.

As the mobile forces increase in size, so is there an expansion of Base Hospitals and other Institutions for the care of the sick and wounded and there should be no lack of officers when required to give to our patriotic boys, that professional attention which is so essential.

It is well for the medical profession of the United States to realize at once that a Medical Reserve Corps of at least 50,000 doctors will be required to meet the demands of the Surgeon General and upon which Corps he can draw for his medical officers.

We believe by this time that the profession of this country must be fully alive to the needs of the Service, so let every doctor who is qualified, feel that he is doing not only his patriotic duty in offering his services as a medical officer, but is relieving the tension of the Surgeon General's Office by placing at the command of the Chief Officer of the Medical Department an adequate force without the frequent beating of drums to supply the necessary number with each increase of the mobile forces.

If you have not already received an application blank for commission in the Medical Reserve Corps, your nearest Examining Board or the Editor of this journal will be glad to supply you.

OUR WAR INTENTIONS.

"WE intend what our forefathers, the founders of this Republic, intended. We in America believe our participation in this war to be the fruitage of what they planted. Our case differs from theirs only in this, that it is our inestimable privilege to concert with men out of every nation what shall make not only the liberties of America secure, but the liberties of every other people as well. * * *

"There can be but one issue. The settlement must be final. There can be no compromise. No

halfway decision would be tolerable. No halfway decision in conceivable. * * *

"The blinded rulers of Prussia have roused forces they knew little of—forces which can never be crushed to earth again; for they have in their heart an inspiration and a purpose which are deathless and of the very stuff of triumph."—*From the President's Mount Vernon Address.*

NO COVENANTED PEACE WITH GERMANY.

AMERICA, unless we repudiate civilization and abandon humanity and put a premium on savagery and brutality, can make no covenanted peace, no peace by agreement or negotiation with Germany. It would be a covenant with hell, a partnership with infamy.

Nor would such a peace secure peace, except so long as it suited Germany. We can judge the future only by the past, and to Germany sacred treaties are scraps of paper only. Germany's whole history is a record of national treachery, national bad faith, national dishonor, national murder, and national infamy.

Article 56 of The Hague Convention, to which Germany solemnly subscribed, is: "Family honor and right, the lives of persons and private property, as well as religious convictions and practice, must be respected. Private property can not be confiscated."

The world knows how Germany has observed this article. There are millions of individual witnesses to her flagrant breaches of it. Every acre of foreign soil Germany has occupied bears mute, but unimpeachable evidence of it. There is plenty of German evidence of it, too.

"The goods of different sorts seized in the enemies' territories are in such large quantities that the difficulty of knowing where to put them increases day by day. At the request of the Prussian minister of war, all chambers of commerce have been asked to give all possible information with regard to storehouses, sheds, etc., which could be used temporarily to warehouse the spoil." (From the Frankfurter Zeitung, January, 1918.)

The German papers have been crowded with advertisements of sale of property taken from France and Belgium. Members of the Reichstag have boasted of, others have censured, the amount of booty brought to Germany from the occupied territory, and the destruction has been far greater than the confiscation.

Of the old men and children murdered, of the women and girls ravished, of the noncombatants taken from their homes and deported to work for their conquerors, of the merchants ships sunk and passengers and crews murdered, of the hospital ships sunk, the hospitals and unfortified cities bombed, of the mutilation and murder by crucifixion and otherwise of wounded and captured soldiers—of all this beastliness there is plenty of evidence, evidence that no one can disbelieve.

The best answer to German peace propaganda is sinking more U-boats, sending more men to France, speeding up our work along every line, and a heavy subscription to the Fourth Liberty Loan. Peace must mean the triumph of right and justice, the defeat of Germanism, not a truce with it, not a compromise with it.

STATE MEETING.

A MOST successful meeting of the State Society was held in Milwaukee, October second to fourth. It is too early as we go to press to report the transactions of the House of Delegates and the election of all the officers and committees. These will be included in the November issue.

A splendid scientific program was given and all social arrangements were up to the usual standard. A total of 329 registered which is an exceptional attendance when the fact is considered that 678 Wisconsin physicians are in service.

Dr. D. J. Hayes of Milwaukee was elected president for the coming year.

REHABILITATION OF OUR WOUNDED.

PERHAPS none of the various uses to which the proceeds of the Liberty Loan are to be devoted appeals more strongly to the American people than the rehabilitation and re-education of our wounded men. To teach these men, to train and fit them for useful and gainful occupations, when by reason of loss of sight or limbs or other injuries they are rendered unable to pursue

ordinary vocations, is a work in which every American has a heartfelt interest.

Compensation will be allowed them and family allowances will be paid their families as if they were in actual service while they are taking the training, and every method known to science will be used to restore our wounded men to health and usefulness.

THE PHYSICIANS AND THE FOURTH LIBERTY LOAN.

Every professional man has a direct personal interest in the defeat of Germany on the basic ground of Patriotism first and in defense of the priceless principle of intellectual liberty. America, France and Great Britain have afforded scientific men the utmost freedom of thought and perfect immunity from the interference of bureaucratic despots and the tyrany of a political programme. The German system has produced many men with the titles "Doktor" and "Geheimrath" but let it not be overlooked that modern pathology dates from Claude Bernard and Louis Pasteur—both Frenchmen. Serum therapy relates not to a Germen but to Elie Metchnikoff, Roux and Behrends, pupils and inheritors of Bernard and Pasteur. Operative surgery unquestionably owes its present triumphant status more to the Americans than to all Germany and Austria combined.

The handicaps of the German system of professional and scientific training are varied and serious, and the worst of all is Tyranny. "L'Etat c'est moi" is the classic formula for Kaiserism in its political aspect. Bad as that is it is nothing as an evil in comparison with "La Science c'est moi" —"L'Art c'est moi"—"LaMusique c'est moi"— and so on. That formula has brought ridicule on most of the modern German art including music and has put the state-academic yoke on more than one of the sciences, including medicine and surgery. Thus the scientific men of America, France and England have more than the universal popular patriotic impulsion to sacrifice, struggle and fight for the complete undoing of Germany and all that is implied in the state system which Germany represents at its worst.

There is no occasion, therefore, to develop at greater length the proposition that every American physician has a great stake in the defeat of the Hohensollern.

The *Fourth Liberty Loan* any way considered is the most important of all. It is the Fighting Loan. Others have been preparatory. This is the one that pulls the trigger and "yanks the lanyards of the Yanks' big guns".

In the very nature of the case, the American physican is pre-eminently qualified to be a master force in the sweeping success of the Loan. In what way? Let's examine the matter.

"Suggestive therapy" is admitted to be an important organ in the equipment of the general practitioner. Even the specialist—yes, even the Surgeon! has found that a large part of his professional success relates to his command of the "psychologic suggestion" that may affect or govern metabolic and pathologic processes in the body. General observation of "practitioner technique" in hundreds of clinical and consultation cases has convinced the writer that "suggestion" aids the Materia Medica in the physician's success in a large proportion of the ordinary cases he is called to attend.

This admitted, everything is admitted regarding the potency of the family doctor everywhere, as a Liberty Loan Worker. Already a master of the arts of "suggestion" he has but to apply his ordinary professional methods for the cure of a malady which is more or less general in America—Liberty Loan *atonicity*. There are many million cases of this disease, to judge by the Treasury reports on the Third Loan results. These cases (though not fatal to the patients themselves) might prove to be all but fatal to the United States Government, if the Credit of the nation were impaired in the eyes of the enemy by a failure to over-subscribe the Fourth Liberty Loan very generously. The reasoning involved is this. Credit is the basis of war and any sign of declining credit is pounded on by the enemy as a symptom of weakness behind the lines, which will appear soon in weakness on the firing line.

Therefore, Gentlemen of the Medical Profession, if you value scientific liberty and the untrammelled advancement of your science, express your convictions and exert your personal and professional influence in your community, for the promotion of interest in the *Fourth Liberty Loan.*

A friendly word from the Family Physician—a confidential word if you please—may be of inestimable value to the Government in effecting an

undreamed of success in the floating of this Fighting Loan.

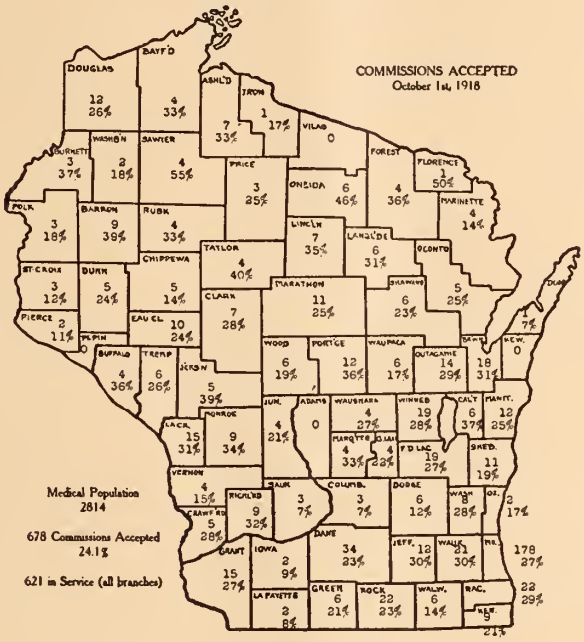
Be on the lookout for the new disease—Liberty bond atonicity.

And when you see a case of it, apply the remedy;

Suggestion: To buy one or many Fourth Liberty Bonds.

MEDICAL MOBILIZATION AND THE WAR

WISCONSIN



OUR SERVICE FLAG

LIST OF WISCONSIN PHYSICIANS IN SERVICE—OCTOBER 1, 1918

(The following list of physicians in service is as accurate as it is possible to make it from the information at hand in the secretary's office. Kindly send in any corrections you may note which should be made to this list. Undoubtedly, the names of some physicians who are in service have been ommitted and it is possible some names have been included of men who are not in service.)

Aaron, Jos., Milwaukee.
Ablemau, T. C. H., Watertown.
Ackermann, Wm., Milwaukee.
Adair, J. W., Kenosha.
Adamkiewicz, L. L., Milwaukee.
Ainsworth, H. H., Madison.
Ainsworth, H., Richland Center.
Albers, E. W., Milwaukee.
Allen, E. P., Waukesha.
Allen, J. S., Norwalk.
Allen, L. L., Wauwatosa.
Allen, W. E., Madison.
Anderson, Jens., Racine.
Andre, F. E., Kenosha.
Andrew, G. F., De Sota.
Andrews, C. W., Waupaca.
Andrews, Neil, Oshkosh.
Angell, E. D., Milwaukee.
Aplin, F. W., Waukesha.
Armitage, J. E., Milwaukee.
Axley, A. A., Butternut.
Baasen, J. M., Mt. Calvary.
Bach, R. J., Milwaukee.
Bachman, H. A., Sheboygan.
Bachinski, L. J., Milwaukee.
Badeaux, G. I., Spooner.
Bading, G. A., Milwaukee.
Baer, C. A., Milwaukee.
Bailey, M. A., Fennimore.
Baird, J. C., Eau Claire.
Baker, G. R., Tomahawk.
Baker, W. F., Birnamwood.
Ballard, J. A., Hayward.
Barnes, Edgar, Ripon.
Barnes, H. T., Pewaukee.
Barrett, E. J., Sheboygan.
Barry, H. J., Sun Prairie.
Bassler, H. H., Oshkosh.
Bauer, E. F., Milwaukee.
Bauer, W. W., Milwaukee.
Baun, E. L., Milwaukee.
Bayer, W. H., Gleason.
Bedford, E. W., Sheboygan.
Beebe, C. M., Sparta.
Beeson, H. B., Cornell.
Beffel, J. M., Milwaukee.
Bellis, G. L., Antigo.
Bendixen, B. O., Kewaskum.
Bennett, J. F., Waterford.
Bennett, L. J., Ft. Atkinson.
Bennett, W. C., Rhinelander.
Benson, G., Richland Center.
Bentley, J. E., Portage.
Berger, A. J., New Holstein.
Bickel, E. F., Oshkosh.
Bird, J. W., Stevens Point.
Birkelo, C. C., Rosholt.
Black, N. M., Milwaukee.
Blanton, S. G., Madison.
Blumenthal, R. W., Milwaukee.
Boeckman, F. A., Greenwood.
Boland, J. E., Two Rivers.
Bolton, E. L., Chilton.
Borchardt, A. C., New London.
Borden, F. R., Plainfield.
Boren, J. W., Marinette.
Bowen, R. L., Oshkosh.
Bowman, F. F., Madison.
Boyd, B. F., Kaukauna.
Boyden, W. L., Seymour.
Brazeau, G. N., Racine.
Breeden, R. F., Richland Center.
Brockway, Frank, Oshkosh.
Broghammer, F. J., Superior.
Brook, J. J., Milwaukee.
Brooks, J. T., Minong.
Brown, R. C., Milwaukee.
Brown, G. V. I., Milwaukee.
Bruins, Dirk, Milwaukee.
Brunckhorst, F. O., Hortonville.
Bryant, J. R., Wausau.
Buckley, W. E., Hartford.
Buell, H. A., Prairie Farm.
Bundy, H. E., Milwaukee.
Burbach, T. H., Milwaukee.
Burns, H. J., Hudson.
Caldwell, H. C., St. Croix Falls.
Campbell, S., Menomonie Falls.
Campbell, W. B., Menomonie Falls.
Carter, H. M., Madison.
Charbonnau, Arthur, Green Bay.
Christensen, J. W., Sparta.
Clark, W. T., Ft. Atkinson.
Clarke, C. P., Janesville.
Clarke, T. C., Oconto.
Clifford, P. M., Green Bay.
Coleman, Harry N., Barron.
Combs, C. J., Oshkosh.
Conklin, G. H., Superior.

Conley, J. G., Darlington.
Conley, J. G., Racine.
Conley, J. M., Oshkosh.
Converse, Geo. L., Webster.
Cook, C. S., Evansville.
Cooke, E. P., Milwaukee.
Cooksey, T. R., Madison.
Coon, G. E., Milton Junction.
Cooper, C. A., Norwalk.
Corcoran, C. J., Milwaukee.
Core, W. J., Milwaukee.
Cornwall, W. B., Turtle Lake.
Corr, J. T., Racine.
Cottingham, M. D., Lake Geneva.
Cowan, W. O., Stevens Point.
Cowles, R. L., Green Bay.
Grambling, H. J., Milwaukee.
Crane, M. C., Osseo.
Christman, E. S., Alnena.
Crowe, N. F., Walworth.
Curtain, A. L., Milwaukee.
Cutler, J. S., Wauwatosa.
Cutting, L. D., Stevens Point.
Dallwig, H. G., Milwaukee.
Darby, G. S., Brodhead.
Darling, F. E., Milwaukee.
Darling, H. C., Milwaukee.
Darling, W. G., Milwaukee.
Darling, W. S., Milwaukee.
Davies, R. E., Waukesha.
Davin, C. A., Weyerhauser.
Davin, C. C., New Richmond.
Dawson, Drexel Lowry, Rice Lake.
Dean, J. P., Madison.
Decker, C. O., Candon.
Decker, H. G., Milwaukee.
Dehmel, R. A., S. Germantown.
DelMarcelle, Dr., Neenah.
Devine, C. B., Marshall.
Devine, G. C., Abbotsford.
Dickinson, G. H., Milwaukee.
Doctor, W. R., Cazenovia.
Dockery, E. E., Ripon.
Dockery, Edwin, Green Bay.
Dodge, C. H., Clinton.
Doege, Karl, Jr., Marshfield.
Donuelly, F. J., Nashotah.
Donohue, W. E., Manitowoc.
Doolittle, S. W., Lancaster.
Doyle, J. N., Neshkord.
Drane, R., Madison.
Draper, M. H., Deerfield.
Dreyer, R. A., Wheeler
Driessel, S. J., Barton.
Drill, A. A., Princeton.
Dudley, L. W., Milwaukee.
DuFrenne, M. F., Sun Prairie.
Durner, U. J., Milwaukee.
Dutton, F. G., Green Bay.
Eastman, J. R., Kenosha.
Ebert, E. C., Milwaukee.
Eck, G. E., Lake Mills.
Edwards, Wm. A., La Crosse.
Egan, Wm. J., Hurley.
Egdahl, A., Menomonie.
Elias, J. F., Milwaukee.
Elliott, R. J., Milwaukee.
Elliott, R. S., Laona.
Elsou, J. C., Madison.
Elvis, E. B., Medford.
Erickson, H. C., Stanley.
Evans, C. A., Milwaukee
Evans, Edward, La Crosse.
Evans, E. P., Milwaukee.
Eyster, J. A., Madison.
Farrell, A. M., Two Rivers.
Faulds, R. C., Abrams.
Farnham, C. R., Milwaukee.
Federman, E. H., Montello.
Ferguson, F. H., Elroy.
Festerling, E. C., Readsville.
Fielder, O. A., Sheboygan.
Fineld, G. W., Janesville.
Finney, W. H., Clintonville.
Fischer, E. H., Milwaukee.
Fitch, R. F., Tomah.
Fitzgerald, G. M., Milwaukee.
Fitzgerald, G. M., Fond du Lac.
Flancher, L. H., Caledonia.
Flancher, L. H., Milwaukee.
Flannagan, G. J., Kaukauna.
Flemiug, F. E., Wausau.
Fleming, Wm. J., Milwaukee.
Flynn, L. H., Eau Claire.
Foat, J. S., Ripon.
Foerster, H. R., Milwaukee.
Forkin, W. P., Chilton.
Fortner, W. H., Princeton.
Fosse, B. O., Beloit.
Foster, A. M., Racine.
Foster, A. M., Kaukauna.
Fowler, P. H., Milwaukee.
Fowler, P. H., Plain.
Fowler, J. H., Lancaster.
Fox, P. A., Milwaukee.
France, J. J., Milwaukee.
Frawley, W. J., Appletou.
Frew, J. W., Milwaukee.
Froney, M. A., Racine.
Fuller, C. O., Stratford.
Fulton, H. A., Eau Claire.
Garner, H. L., Rhinelander.
Gates, A. J., Tigerton.
Gates, E., Two Rivers.
Gaterdau, E. A., La Crosse.
Gavin, S. E., Fond du Lac.
Gendron, A. E., River Falls.
Gereud, A., Cato.
Giesen, C. W., Superior.
Gilchrist, R. T., Milwaukee.
Gillespie, W. W., Milwaukee.
Gillette, H. E., Amherst Junction.
Gillette, H. F., Packwaukee.
Gillis, J. D., Antigo.
Gillis, J. P., Deerbrook.
Gosin, D. F., Green Bay.
Gosin, F. J., Greeu Bay.
Gotsche, E. F., Racine.
Gotterdam, E. A., Milwaukee.
Gramling, H. J., Milwaukee.
Graebner, H. H., Milwaukee.
Grannis, I. V., Menomonie.
Gratiot, W. M., Mineral Point.
Gray, A. W., Milwaukee.
Gray, R. H., La Crosse.
Grisson, C. B., La Crosse.
Griswold, C. M., Alma Center.
Griswold, G. W., Alma Center.
Grosskopf, E. C., Milwaukee.
Grotjan, W. F., Milwaukee.
Ground, H. S., Superior.
Ground, W. E., Superior.
Gunderson, C. A. S., Deerfield.
Gunderson, M. O., Beloit.
Gunther, O. T., Sheboygan.
Hafemeister, E. C., North Prairie.
Hager, F. J., Denmark.
Haggerty, E. E., La Farge.
Hake, Cecil B., Milwaukee.
Hall, B. M., Milwaukee.
Hall, M. W., Mondovi.
Hall, R. M., Milwaukee.
Hanley, W. J., Kenosha.
Halsey, H. A., Hiles.
Haney, F. C., Watertown.
Hansen, J. W., Milwaukee.
Hansou, E. W., Three Lakes.
Hansou, W. C., Racine.
Harding, J., Hudsou.
Harkins, J. P., Forest Junction.
Harris, F. M., Fond du Lac.
Harrison, D. C., Mason.
Harrisou, Geo. W., Ashland.
Harvie, W. D., Oshkosh.
Harvey, G. R., Footville.
Hayes, E. P., Eau Claire.
Hawley, F. M., Bayfield.
H'Doubler, F. T., Madison.
Hebron, R. A., Cataract.
Hecker, W. H., Beloit.
Hefty, C. A., New Glarus.
Heim, Russell, Marinette.
Heise, H. A., Madison.
Helm, H. M., Beloit.
Hendrickson, H., Green Bay.
Hennig, E. L., Beloit.
Heraty, J. E., Bloomingtou.
Hinrichs, R. G., Ashland.
Hitz, H. B., Milwaukee.
Hodges, P. C., Madison.
Hoffman, G. H., Milwaukee.
Hoffman, J. G., Hartford.
Hoffman, L. A., Milwaukee.
Hoffman, L. A., Campbellsport.
Hogan, J. H., Racine.
Hogue, G. D., Milwaukee.
Holmes, B. H., Delavan.
Howard, T. J., Milwaukee.
Howell, E. C., Fennimore.
Hudek, D. F., Statesan.
Huff, F. C., Sturgeon Bay.
Hughes, C. W., Winneconne.
Hugo, D. G., Oshkosh.
Hunter, C. M., Stetsonville.
Hutchins, S. E., Whitehall.
Ishmael, O. E., Mt. Horeb.
Ivy, R. M., Milwaukee.
Jackey, F. D., Thorpe.
James, A. W., Muscoda.
Jefferson, H. A., Clintonville.
Jenner, A. G., Milwaukee.
Johnson, A. T., Sauk City.
Johnson, A. W., Milwaukee.
Johnson, C. H., Racine.
Johnsou, J. C., Ogdensburg.
Johnston, W. W., Racine.
Jones, M. L., Wausau.
Jones, W. J., Rockland.
Joseph, W. A., Hancock.
Kalling, H., Black River Falls.
Kampmeier, A. J., Milwaukee.
Kay, H. M., Madison.
Kayseu, Ralph, Watertown.
Kayseu, R., Milwaukee.
Keenan, H. A., Stoughton.
Keeuan, T. P., Milwaukee.
Kiethley, J. A., Palmyra.
Kelly, C. D., Blair.
Kennedy, F. H., Greeuwood.
Kenney, C. J., Milwaukee.
Kenney, G. F., Milwaukee.
Kenney, R. L., Milwaukee.
Kersten, E. M., Two Rivers.
King, Geo. F., Green Bay.
Klein, J. T., Milwaukee.
Kuapp, E. J., Rice Lake.
Kuox, E. S., Bowler.
Kolls, A. C., La Crosse.
Korthals, F. J., Milwaukee.
Kracow, F. C., Milwaukee.
Krahan, G. W., Oconto Falls.
Kuhn, H. J., Milwaukee.
Kulig, A. H., Dodge.
Kyes, S. M., Owen.
Kyllo, A. L., Grautsburg.
Kyllo, J. C., Superior.
Lademan, O. E., Milwaukee.
Lando, David, Milwaukee.
Lapham, E. A., Rib Lake.
Larson, G. H., Pewaukee.
Lasche, P. G., Richland Center.
Lauder, C. E., Viroqua.
Laughlin, T., Winneconne.
Lawrence, G. H., Fond du Lac.
Lawhorn, C. C., Milwaukee.
Leacy, J. D., Milwaukee.
Leicht, P., Lake Mills.
Leutsker, R., Antigo.
Lewis, P. J., Bloomington.
Lewis, Sherman T., Milwaukee.
Liefert, F. C., Milwaukee.
Lillie, O. R., Milwaukee.
Lindow, G. E., Watertown.
Linkman, E. G., Milwaukee.
Lockhart, C. W., Mellen.
Lockhart, J. W., Oshkosh.
Lohmiller, R. K., Superior.
Longely, J. R., Fond du Lac.
Looze, A. J., Brodhead.
Lorenz, W. F., Mendota.
Loughlin, T. F., Milwaukee.
Ludden, H. D., Mineral Point.
Lynch, D. W., West Bend.
Lynch, H. M., Allenton.
Lyon-Campbell, A. F., Florence.
McBeath, N. E., Livingston.
McCarey, A. J., Green Bay.
McCarthy, H. C., Richland Center.
McCorkle, S. C., Milwaukee.
McCormick, W. C., Tomahawk.
McCoy, H. J., Milwaukee.
McDill, J. R., Milwaukee.
McEachern, W. A., Superior.
McGarty, M. A., La Crosse.
McGinnis, J. E., Greeu Bay.
McGrath, E. F., Appleton.
McJuukin, F. A., Milwaukee.
McKee, E. W., Richland Center.
McLaughlin, F. H., Milwaukee.
McMahon, F. B., Milwaukee.
McNary, J. F., Milwaukee.
McNaughton, W. T., Milwaukee.
McNicholas, L. T., Athens.
MacCormack, R. L., Alma Center.
Mackedon, T. E., Cedarburg.
Madison, J. D., Milwaukee.
Maercklein, O. W., Milwaukee.
Maercklein, A. G., Exeland.
Magill, E. C., Madison.
Majerus, P. J., Sullivau.
Malcolm, J. J., Chetek.
Malkin, G. M., Milwaukee.
Marshall, V. F., Appleton.
Martin, C. D., Milwaukee.
Mason, E. L., Eau Claire.
Maurer, Albert A., La Crosse.
Maurer, H. C., Beloit.
Mecum, J. M., Bagley.
Mehigan, D. D., Milwaukee.
Mehl, H. F., Milwaukee.
Mensing, E. H., Milwaukee.
Merrill, W. G., Grand Rapids.
Mertens, H. G., Bayfield.

Meyer, H. C., La Crosse.
Meyst, C. H., Burlington.
Middleton, W. S., Madison.
Midgley, A. E., Whitewater.
Miller, H. C., Whitewater.
Miller, Thomas, Oconomowoc.
Miller, W. P., Milwaukee.
Minahan, J. J., St. Nazianz.
Minahan, P. R., Fond du Lac.
Mitchell, E. J., Brodhead.
Mitchell, S. R., Milwaukee.
Mitten, A. A., Milwaukee.
Mix, H. C., Green Bay.
Mueller, W. E., Green Bay.
Montgomery, R. C., Madison.
Moutgomery, Wm., Eau Claire.
Moore, L. A., Monroe.
Moore, W. N., Appleton.
Moquin, E. L., Fairwater.
Mortell, G. T., Green Bay.
Mountain, J. M., Milwaukee.
Mulsow, J. E., Milwaukee.
Mulsow, J. E., Two Rivers.
Munn, W. A., Janesville.
Murphy, E. R. F., Antigo.
Murphy, W. T., Wankesha.
Myrick, A. L., Eastman.
Nause, F. A., Sheboygan.
Nies, F. P., Gilman.
Niemann, A. C., New Holstein.
Nielson, G. W., Milwaukee.
Nelson, J. D., Milwaukee.
Nelson, N. O., Madison.
Nelson, O. A., Park Falls.
Nelson, R. N., Horicon.
Newall, F., Burlington.
Nichols, R. M., Sheboygan Falls.
Nims, C. H., Oshkosh.
Nothbohm, D. L. R., Dousman.
Nugent, A. C., Milwaukee.
Nuzum, T. W., Janesville.
Oates, Frank, Fond du Lac.
O'Brien, H. N., Darien.
Oliver, C. H., Boyceville.
Oliver, L. H., Siren.
Olson, Alfred L., Stoughton.
Olson, R. E., Milwaukee.
Ouellette, G. J., Oconto.
Palmer, J. A., Arcadia.
Parke, Geo., Viola.
Parker, A. S., Clinton.
Parker, T. G., Rome.
Parmenter, E. L., Mondovi.
Partridge, O. F., Mattoon.
Paulus, D. D., Random Lake.
Pearson, C. M., Ogema.
Pearson, L. M., Tomahawk.
Perry, Gentz, Amery.
Petersou, N. A., Soldiers Grove.
Pfeffer, E. N., Milwaukee.
Pfeifer, E. C., Loyal.
Pfeil, R. C., Thiensville.
Phelps, E. J., Elderou.
Phillips, L. J., Weyerhauser.
Pierson, P. R., Readstown.
Pippan, I. B., Excelsior.
Pleyte, A. A., Delafield.
Pollasky, H. D., Milwaukee.
Pomainville, F. X., Graud Rapids.
Pope, F. W., Racine.
Post, C. C., Barron.
Potter, R. P., Marshfield.
Powers, J. W., Burlington.
Powless, Dr., W. DePere.
Pretts, W. M., Platteville.
Prill, H. J., West Salem.
Pullen, A. J., North Fond du Lac.
Quinn, R. B., Darlington.
Randall, A. J., Kenosha.
Rautz, C. B., Weyerhauser.
Rantz, W. L., Rosholt.
Randall, G. R., Milwaukee.
Ravn, E. O., Merrill.
Reay, G. R., La Crosse.
Reddick, G. H., Wabeno.
Redelings, L. H., Marinette.
Rehling, C. F., Fremout.
Reineking, W. C., Wales.
Remer, W. H., Chaseburg.
Reuthin, K. A., Ridgeland.
Richards, C. A., Rhinelander.
Richards, W. M., Platteville.
Riechhoff, G. G., Milwaukee.
Riley, D. B., Milwaukee.
Riley, E. A., Park Falls.
Ripley, H. M., Kenosha.
Roberts, Vernon, Natioual Home.
Robinson, B. N., Prairie du Chieu.
Robinson, H. A., Kenosha.
Roby, H. S., Milwaukee.
Rodecker, R. C., Holcombe.
Rogers, P. F., Milwaukee.
Rollefson, C. J., Superior.
Rosholt, Jens, La Crosse.
Ross, P. M., Milwaukee.
Rowe, L. B., Brodhead.
Rowley, B. B., White Fish Bay.
Rowley, C. C., Winnebago.
Rueth, J. E., Sun Prairie.
Ruke, E. A., Boscobel.
Ruschaupt, L. F., Milwaukee.
Russell, F. H., Neeuah.
Russell, H. C., Milwaukee.
Ryau, E. R., Milwaukee.
Rydell, C. B., Superior.
Salbreiter, W. P., Racine.
Saltzstein, H. C., Milwaukee.
Sanders, A. O., Superior.
Sargeut, H. L., Milwaukee.
Saylor, H., Merrill.
Scaulau, P. L., Prairie du Chien.
Scantleton, J. M., Sparta.
Schaefer, C., Racine.
Scheik, I. E., Rhiuelander.
Schlaikowski, J. P., Milwaukee.
Schlegel, H. T., Wausau.
Schlenker, G. H., Cazenovia.
Schlesselman, G. H., Fond du Lac.
Schneider, J. F., Oshkosh.
Schnetz, L. N., Racine.
Scholter, E. A., Milwaukee.
Schoofs, O. P., Johnsburg.
Schroeder, E. L., Shawano.
Schubert, F. J., Milwaukee.
Schwarz, S. G., Humbird.
Schwartz, A. B., Milwaukee.
Scott, B. E., Berlin.
Scott, J. C., Marinette.
Scott, J. R., Appleton.
Seaman, G. E., Milwaukee.
Seeger, S. J., Milwaukee.
Seemann, W. O., Eau Claire.
Segal, G. M., Milwaukee.
Senn, C. U., Ripon.
Senn, Geo., DePere.
Seun, Ulrich, Milwaukee.
Sennett, J. F., Milwaukee.
Sexton, W. G., Marshfield.
Sharp, E. L., Plymonth.
Shearer, A. T., Edgerton.
Shearer, F. E., Edgertou.
Sheehy, Thos. J., Tomah.
Sheehau, J. R., Milwaukee.
Shimek, A. J., Manitowoc.
Shiunick, T. F., Beloit.
Shippy, V. J., Stevens Poiut.
Sickels, W. A., Milwaukee.
Simpson, J. E., Endeavor.
Sincock, Henry A., Odanah.
Sisk, I. R., Madisou.
Siver, A. W., Milwaukee.
Sleyster, Rock, Waupun.
Smiley, R. B., Stevens Point.
Smith, A. D., Gilmanton.
Smith, C. E., Amherst.
Smith, E. A., Milwaukee.
Smith, Geo. M., Chippewa Falls.
Smith, H. A., Winter.
Smith, J. W., Milwaukee.
Smith, E. W., Madison.
Smith, L. G., Ellsworth.
Smith, S. M. B., Wausau.
Snodgrass, T. J., Janesville.
Sonnenburg, C. N., Sheboygan.
Sondel, L. C., Milwaukee.
Spencer, G. F., Evansville.
Stachle, Max, Manitowoc.
Stamm, L. P., Milwaukee.
Starnes, Brand, Maustou.
Steenberg, H. S., Milwaukee.
Steffen, L. A., Antigo.
Stephenson, W. L., Ladysmith.
Stoland, I., Eau Claire.
Stolz, C. E., Milwaukee.
Stneck, A. F., Milwaukee.
Stneck, A. F., Michicott.
Stuesser, C. N., Oconomowoc.
Sullivan, G. A., Milwaukee.
Sutherlaud, J., Brodhead.
Sutter, E. H., Milwaukee.
Sykes, L. G., Milwaukee.
Sylvester, H., Montfort.
Taylor, J. G., Milwaukee.
Taylor, F. B., Madisou.
Taylor, L. L., Waupun.
Taylor, W. A., Portage.
Tharinger, E. L., Milwaukee.
Thielke, G. A., Wausau.
Thompson, A. S., Mt. Horeb.
Thompson, E. X., Cudahy.
Thompsou, F. A., Milwaukee.
Thompson, G. E., Kenosha.
Thompsou, J. B., Wittenburg.
Thompson, R. D., Reedsburg.
Thompson, W. J., Portage.
Towle, G. E., Mosinee.
Townsend, D., Ocouomowoc.
Towuscud, E. H., New Lisbon.
Treglown, L. H., Livingston.
Treichler, M. J., Hancock.
Trock, M. J., Milwaukee.
Trowbridge, P. T., Washburn.
Tuffley, F. S., Boscobel.
Twohig, J. Elmer, Fond du Lac.
Tyvand, J. C., Whitehall.
Van de Erve, Wm., Montello.
Van der Linde, L. A., Wautoma.
Vau Heck, D. S., Merrill.
Vankirk, F. W., Janesville.
Vedder, J. B., Marshfield.
Vogel, C. C., Elroy.
Voorus, L. O., Beaver Dam.
Walch, F. C., Black Creek.
Wallschlaeger, G. G., Milwaukee.
Walter, F. A., Steveus Point.
Warfield, L. M., Milwaukee.
Watkins, C. W., Oconto.
Waufle, Guy, Janesville.
Webb, E. P., Beaver Dam.
Weber, A. J., Milwaukee.
Wedge, Athol H., Waupun.
Weingart, Wm., Milwaukee.
Wengleski, J. F., Milwaukee.
Wheatley, C. I., Milwaukee.
White, A. S., Rice Lake.
Whiteside, C. D., Plover.
Whyte, W. F., Madisou.
Wilkinsou, J. J., Milwaukee.
Wilkinsou, M. R., Oconomowoc.
Wilkowski, C. W., Chippewa Falls.
Willett, Thos., West Allis.
Willhite, O. C., Lake Geneva.
Williams, A. E., Eau Claire.
Williams, A. J., Waukesha.
Wilske, Chas. A., Milwaukee.
Wilson, R. S., Milwaukee.
Winneman, W. J., Atheus.
Winter, A. E., Tomah.
Witte, D. H., Hartford.
Witte, Dexter H., Milwaukee.
Wolters, H. F., Milwaukee.
Woodhead, F. J., Merten.
Yates, John L., Milwaukee.
Youmans, L. E., Mukwouago.
Ziegler, J. E. B., Ean Claire.
Zuercher, J. C., La Crosse.

SHALL VENEREAL DISEASE MENACE THE NATION?

The Council of National Defense urges public officers and citizens of the United States to employ every means possible in the repression of prostitution and the control of venereal disease, for the following reasons:

First, because we must prevent such conditions as have developed in Europe since the beginning of the war.

(1) "The number of syphilitics in the army must certainly be several hundreds of thousands . . . Since the war began, a total equivalent of sixty divisions have been temporarily withdrawn from the fighting for

venereal diseases." (Vienna report)—Journal of the American Medical Association, March 10, 1917, Vol. 68, No. 10, p. 814.

(2) "During the first eighteen months of war one of the great powers had more men incapacitated for service by venereal disease contracted in the mobilization camps than in all the fighting on the front."—Social Hygiene, Vol. 3, No. 2, p. 205.

(3) In the war zone of France there has occurred an alarming increase of venereal disease both amongst the soldiers and the civilian population.—The Medical Officer (London), No. 499, March 3, 1917.

(4) "The failure of the . . . Government to protect their soldiers from these evils (sexual vice and alcoholism) is the gravest error that the Government has committed: for these vices have proved more destructive to the . . . people since August, 1914, than all the . . . artillery, rifles, hand grenades, poisonous gases and fire blasts. Those killed by shot and shell transmit no poison to their families and descendants—the victims of alcohol and prostitution do." —From a letter by President Emeritus Charles W. Eliot of Harvard University quoted in the Survey of Sept. 8, 1917.

(5) "Thousands upon thousands are withdrawn from the fighting army for weeks. But they are not only missed as fighters, they also cause expense and great obstruction through their transportation back home through the necessity of establishing hospitals for thousands who were not wounded by the enemy. They burden the doctors so necessary for the care of the wounded . . .

"But the very worst part of the venereal diseases is not the diseased condition immediately following infection but the ailments frequently developing in later years, when the war is long past and the old infection already forgotten, and the transmission of the disease to the family after the return of the troops to their homes."—Prof. Albert Neisser, Frankfurther Zeitung, January, 1915.

Second, because serious conditions have already developed in the United States Army, due largely to conditions in civil communities.

(1) At one National Guard camp, 502 new cases of venereal disease were reported in one week.—Official Bulletin, Nov. 20, 1917, p. 6.

(2) It was found that most of the cases at one large cantonment originated, not in the camp or near the camp, but in civil communities from which the men came or through which they passed on the way to camp.

(3) "In the case of all the troops on the border, a vastly larger proportion of venereal disease was contracted before reaching the border than was contracted afterwards."—Social Hygiene, Vol. 3, No. 2, p. 220.

Third, because the War Department has asked our aid.

(1) "Our responsibility in this matter is not open to question. We cannot allow these young men . . . to be surrounded by a vicious and demoralizing environment, nor can we leave anything undone which will protect them from unhealthy influences and crude forms of temptation."—Secretary of War Baker in his letter of May 26, 1917, to Governors of all states.

(2) "We are not going to be able to obtain the conditions necessary to the health and vitality of our soldiers, without the full co-operation of the local authorities in the cities and towns near which our camps are located or through which our soldiers will be passing in transit to other points."—Ibid.

Fourth, because venereal diseases result in the infection of innocent women and children.

(1) "No disease has such a murderous influence upon the offspring as syphilis; no disease has such a destructive influence upon the health and procreative function of women as gonorrhea. . . . Inherited syphilis constitutes a powerful factor in the degeneration of the race."—Prince A. Morrow, M. D.; Social Diseases and Marriage, Chap. 1.

(2) "All previous war experience shows an increase of venereal disease . . . When peace comes there is the danger of grave and widespread dissemination of these diseases. It is for that, that we must be prepared and there is no time to be lost."—Report of National Conference for Combating Venereal Diseases (London). Social Hygiene, Vol. 3, p. 235, No. 2.

Fifth, because prostitution is not a "necessary evil".

(1) "Sexual intercourse is not necessary to preserve health and manly vigor."—Moss; Manual of Military Training, Section 1466, p. 522. See also statement signed by Walter B. Cannon, M. D., Harvard University, William H. Howell, M. D., Johns Hopkins University and 355 other foremost medical authorities in the United States.—M. J. Exner, M. D.; The Physician's Answer. (Association Press, New York), pp. 14, 24-51.

Sixth, because the "restricted district" and other attempts to regulate prostitution, have proved ineffective.

(1) See Flexner: Prostitution in Europe, pp. 175-6 and the reports of Vice Commission in Chicago, Minneapolis, Syracuse, Philadelphia and many other cities.

Seventh, because repression is the only feasible method.

(1) "The only practical policy which presents itself in relation to this problem is the policy of absolute repression, and I am confident that in taking this course the War Department has placed itself in line with the best thought and practice which modern police experience has developed."—Secretary of War Baker in his letter of August 14, 1917, to Mayors and Sheriffs.

(2) "This policy involves, of course, constant vigilance on the part of the police, not only in eliminating regular houses of prostitution, but in checking the more or less clandestine class that walks the streets and is apt to frequent lodging houses and hotels."—Ibid.

Eighth, because it will be better to handle the situation locally and thus make military interference unnecessary.

(1) On Commandant issued orders forbidding all use of intoxicating liquor and all patronizing of immoral resorts. Every woman who got off a train was watched until her business was known. If necessary she was put out of the vicinity.—Social Hygiene, Vol. 3, No. 1, p. 155, also Association Men (New York), April, 1917, p. 379.

(2) "If places of bad repute spring up outside the 5 mile limit, but fairly accessible to the camp, I shall not hesitate to insist upon their elimination."—Secretary of War Baker in his letter of August 14, 1917, to Mayors and Sheriffs.

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in Combating Venereal Diseases,
Council of National Defense,
Washington, D. C.

VOLUNTEER MEDICAL SERVICE CORPS OF THE UNITED STATES.

Authorized by the Council of National Defense, Approved by the President of the United States.

INFORMATION.

1. What is the Volunteer Medical Service Corps?

The Volunteer Medical Service Corps is an organization which provides means for obtaining quickly men and women for any military or civil medical service required in the war emergency. It furnishes recommendations and necessary credentials to assure the best medical service, both military and civil.

2. How should application for membership be made?

Upon request to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C., application blanks and circulars of information will be sent. When received, the application form should be filled out completely, in accordance with instruction contained in the circular of information. The application should then be mailed to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

3. What is to be gained by the creation of this organization.

Placing on record all medical men and women in the United States; aiding Army, Navy, Public Health Service, Provost Marshal General's Office and the American Red Cross in supplying war medical needs; providing the best civilian medical service possible; giving recognition to all who record themselves either in Army, Navy, Public Health Service, Provost Marshal General's Office, Red Cross activities or civilian service.

4. What is meant by classification?

It is the record of information furnished by the individual physician so that when the need arises, he may be requested to perform service that will be mutually advantageous to the individual and the service to which he may be assigned.

5. Who are eligible?

Every legally qualified physician holding the degree of Doctor of Medicine from a legally chartered medical school without reference to age or physical disability is eligible for membership in the Volunteer Medical Service Corps provided he or she is not already commissioned in the Government service.

6. How is eligibility to the Corps determined?

Upon information obtained from application blanks, three personal references and the Executive Committee of the state in which the applicant resides. Based upon the information thus secured, the Central Governing Board will finally pass upon applications.

7. Does membership in the Corps carry with it rank and pay?

This Corps is not authoried to bestow rank. Arrangements for compensation shall be made between a member requested to perform a specific duty and the agency requesting service. The matter of compensation and place of service whether with or without rank must be determined at the times said request is made. When a member of the Corps accepts service in the Medical Reserve Corps of the Army, the Naval Reserve Force, the United States Public Health Service, the American Red Cross or any governmental department, he or she will be accorded the rank and pay incident to the service in the department in which he or she has enrolled.

8. Will any member of this Corps be ordered to active duty?

No member will be ORDERED to render any service. Requests to perform specific duties according to qualifications and availability under the classification of the Volunteer Medical Service Corps may be made from time to time as emergencies arise.

9. What will be the probable character of service member will be requested to render?

(a) Medical Reserve Corps.
(b) Naval Reserve Force.
(c) United States Public Health Service.
(d) American Red Cross.
(e) Local and medical advisory boards.
(f) State and local health departments.
(g) Medical Schools and Hospitals.
(h) Industrial plants.
(i) Civil communities.

Caring for civil communities, stripped of medical attention. Caring for practices of physicians in military service. Reclamation of registrants rejected for physical unfitness. Services to needy families and dependents of enlisted men.

(j) Miscellaneous service.

10. If members of the Corps are recommended for active military or naval service, in what order will they be recommended.

(a) Physicians under 55 years of age without dependents and without physical disabilities which are disqualifying will first be recommended. Following this group, physicians under fifty-five years of age without obvious physical disabilities which are disqualifying and with not more than one dependent in addition to self (Class I of the Volunteer Medical Service Corps) will be among the first to be recommended for actual war service. Any physician under fifty-five years of age who is without an obvious physical disability which is disqualifying and whose dependents have an income sufficient for the support of dependents other than that derived from the practice of his profession, may be recommended to enroll in the Medical Reserve Corps of the Army, the Naval Reserve Force or the United States Public Health Service when in the opinion of the respective Surgeons General his services are needed.

(b) Physicians under fifty-five years of age without obvious physical disabilities which are disqualifying and with not more than three dependents in addition to self (Class II of the Volunteer Medical Service Corps) will be the next group to be recommended to apply for active military or naval service.

(c) The next group recommended to enroll for active duty which the Army, Navy or Public Health Service (Class III), will be physicians under fifty years of age who are without obvious physical disabilities which are disqualifying and with more than three dependents in addition to self.

11. What are the exceptions in these groups?

The exceptions in the above groups of physicians are as follows:

(a) Those essential to communities.

(b) Those essential to medical schools and hospitals.

(c) Those essential to health departments.

(d) Those essential to industries.

(e) Those essential to local and medical advisory boards.

12. How will exceptions to these groups be determined?

(a) *Essential to communities.*

Essential community need will be determined by the Central Governing Board on recommendation of representatives of the Central Governing Board appointed by the Board to make a survey of local conditions.

(b) *Essential to institutions.*

Essential institutional need will be established after conferences between representatives of the Central Governing Board of the Volunteer Medical Service Corps and representatives appointed by the governing bodies of the institutions concerned.

(c) *Essential to health departments.*

Essential health department need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of health departments.

(d) *Essential to industries.*

Essential industrial need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and accredited representatives of industries involved.

(e) *Essential to local and medical advisory boards.*

Essential local and medical advisory board needs will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of the Provost Marshal General's Office.

13. When will physicians who are not classified for actual military or naval service be requested to perform service?

When the emergency arises the following may be requested to perform duties in accordance with their qualifications and expressed merits as indicated by the information contained on their application blanks:

(a) Physicians over fifty-five years of age.

(b) Physicians with obvious physical disabilities which are disqualifying.

(c) Those rejected for all government service because of physical disability.

14. What are some of the duties that this last group of physicians ineligible for active military service may be requested to perform?

(a) Deducting those members of the medical profession who will eventually be in active military, naval or public health service, fully seventy-five per cent of the remainder will be encouraged to continue at their home duties.

(b) Some of these may be called upon to supplement their private practices by performing part time service to meet community needs hitherto performed by men called to active duty.

(c) Twenty-five per cent of those not actually engaged in war service (possibly 20.000 in number) who are now engaged in home duties but who have agreed to do work of any kind, anywhere, upon request of the Central Governing Board, will as the emergency arises be recommended for duty in the following places:

1. Local and medical advisory boards.
2. Medical schools and hospitals.
3. Industrial plants.
4. Health departments.
5. Communities lacking medical service.

15. How does enrollment in this Corps differ from actual conscription?

The Volunteer Medical Service Corps is exactly what its name indicates. It is a gentleman's agreement on the part of the civilian doctors of the United States who have not yet been commissioned in the Army or Navy or enrolled in the Public Health Service, or in the service of the Provost Marshal General, and a representative board consisting of government officials associated with lay members of the profession in which the civilian physicians agree to offer their services to the Government if requested to do so by the Central Governing Board.

16. In what way can this Corps aid the Government?

By recording all physicians who are not yet in service and classifying them so as to utilize the talents and facilities of individuals to the best advantage and inflict as little hardship on the individual as possible, in accordance with the letter from the President of the United States authorizing the Corps—"to supply the needs of the Army, Navy and Public Health Service . . . aiding in the important work of the Provost Marshal General's Office and Red Cross . . . and the problems of the health of the civilian communities of the United States." It provides a method by which every physician not in uniform will be entitled to wear an insignia which indicates his willingness to serve his Government. It furnishes a method by which the medical needs of the nation may be provided for through a representative board of physicians who know the needs of the Army, Navy, Public Health Service, Red Cross and civil communities.

17. To what extent must provision be made for essential civilian and industrial medical needs?

A large percentage of the physicians of the country will be required to care for their respective home communities and to meet civilian health needs. This percentage of necessity will be expected to maintain their home status and continue their professional work.

18. Will enrollment in the Volunteer Medical Service Corps excuse a physician in the draft age from registration under the Selective Service Law or from being classified therein.

Positively not.

19. Why then enroll in the Volunteer Medical Service Corps if it does not supplant the draft?

(a) Under the Selective Service Law individuals in the draft age are registered and inducted into the service as privates. The Volunteer Medical Service Corps enrolls and classifies individuals as prospective commissioned officers and will when requested assist in establishing the individual's status when he requests transfer from the enlisted forces to the commissioned branches of the service.

(b) Enrollment in the Volunteer Medical Service Corps definitely registers the physician as a patriot and provides definite governmental recognition of his willingness to serve.

20. Why should every physician in the United States enroll in the volunteer Medical Corps?

(a) The unsurpassed record of volunteer enrollment for actual service on the part of the medical profession must be maintained.

(b) The Army and the Navy must not be hampered for a moment for lack of doctors to care for the sick and wounded boys fighting our battles at the front.

(c) The public health must be conserved.

(d) The medical needs of the Provost Marshal General must be adequately met.

(e) The great industries furnishing materials of war employing thousands of patriotic workers, must have medical service.

(f) The home folks, the old and the young wearily waiting over here, must have doctors.

(g) Recording, classifying, and careful distribution and full utilization of our entire profession of medicine will enable us to instantly supply all demands, and our utmost resources will then be available to aid in establishing a permanent peace that will forever make this world a safe place in which women and children may live.

WAR WORK FOR YOUNG WOMEN.

The Surgeon General's Office, War Department has issued an urgent call for young women to serve in reconstruction hospitals at home and abroad. The Normal School of Physical Education, Battle Creek, Michigan, which is affiliated with the Battle Creek Sanitarium, wishing to do its share toward winning the war, has inaugurated a course in physiotherapy, which meets the requirements of the War Department. Courses begin Oct. 1st and Feb. 1st. Length of course is 4 months. The curriculum consists of Anatomy, Physiology, Hygiene, Bandaging, Active and Passive Movements, Hydrotherapy, Massage, Electrotherapy, and Clinics.

The Medical profession are asked to direct the attention of young women who are planning to engage in war work to this unusual opportunity.

Further information may be obtained from Frank J. Born, M. D., Director of the School.

TURN IN YOUR PLATINUM.

From: Lieut. Colonel F. F. Simpson, M. C., N. A., Chief of Section of Medical Industry.

To: The Doctors and Dentists of the Country.

Subject: Utilization of Platinum in Unused Instruments.

1. In view of the limited supply of platinum in the country and of the urgent demand for war purposes, it is requested that every doctor and dentist in the country go carefully over his instruments and pick out *every scrap of platinum* that is not absolutely essential to his work. These scraps, however small and in whatever condition, should reach Governmental sources without delay, through one of two channels:

(a) They can be given to proper accredited representatives of the Red Cross who will shortly make a canvas for that purpose.

(b) They may be sold to the Government through any bank under the supervision of the Federal Reserve Board. Such banks will receive and pay current prices for platinum.

By giving this immediate attention you will definitely aid in the war program.

2. It is recognized that certain dental and surgical instruments requiring platinum are necessary, and from time to time platinum is released for that purpose. It is hoped, however, that every physician and every dentist will use substitutes for platinum for such purposes wherever possible.

3. *You are warned* against giving your scrap platinum to anyone who calls at your office without full assurance that that individual is authorized to represent the Red Cross in the matter.

F. F. SIMPSON,
Lieut. Col. F. F. Simpson, M. C., N. A., Chief of Section of Medical Industry.

AN UNPRECEDENTED OPPORTUNITY FOR WOMEN.

BY EMMA WHEAT GILLMORE, M. D.,

Chairman Committee of Women Physicians, General Medical Board, Council of National Defense.

The same year that gold was discovered in California, a lone pioneer received the first medical diploma which the United States had issued to a woman. Other colleges shortly followed the example of the one which had opened its doors to Elizabeth Blackwell, and today over fifty co-educational medical schools admit women upon the same terms as men.

There are more than 25,000 American physicians in military service at this writing, and the Council of National Defense is undertaking, through the Volunteer Medical Service Corps—an organization which has President Wilson's approval—the task of classifying the qualifications of ninety thousand more. Of these, about six thousand are women, less than one-third of whom have registered with the General Medical Board.

Women of the profession, unless our qualifications are standardized and on file, can you not see that we are an unknown quality and quantity as far as the Government is concerned? In spite of the overwhelming difference in number—6,000 women and over 100,000 men—and regardless of the fact that over twenty-two centuries have passed since Hippocrates wrote the immortal Oath and only sixty-nine years have elapsed since women entered the medical profession, the Volunteer Medical Service Corps has invited them to membership with the same impartial cordiality as it has the men.

During the last week in August application blanks for the Volunteer Medical Service Corps were mailed in franked envelopes to all legally qualified men and women in the United States who were not already in Government Service. Presumably a number of women have been overlooked because many of them are not members of medical societies, but this will speedily be corrected if a notification of the omission is sent to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

Meanwhile, medical women who possess a vision will see in the Volunteer Medical Service Corps an incomparable method of organization which will register their qualifications and place them in an identical coded class system with men physicians. This Corps is in reality an ideal procedure for mobilizing the military forces of our country for selective medical war service. Incidently it will place loyal and patriotic medical women by the side of those men who are willing to give themselves. Even though all of them are not elected to membership, their names will be on file with the Government as willing to serve as far as their strength and capability will permit, and no one can point a finger at them and say "slacker".

Will a page be turned over in the history of American Medical Women upon which will be written the qualifications of 6,000 of them, matching that group of English physicians known as the Scottish Women's Hospitals, which was so perfectly organized that they were able to hand over to their Government a constructively organized body of professional women for military service? Or shall we continue, as we have done in sporadic groups for the past 69 years, to demand recognition of men and at the same time neglect to unanimously affiliate with them in recognized medical societies, and to withhold our influence both with pen and vote when medico-social and medico-political and medico-scientific issues are at stake which shake the very foundation upon which medicine rests?

The body politic of the civilied world holds a prominent place for the profession of medicine in the near future. Are we to have a hand in shaping it? The Volunteer Medical Service Corps is big with promise for women of the medical profession if we take advantage of it to put ourselves on record. The response which the Council of National Defense receives from women who apply for membership will tell the tale as to whether they have or have not grasped and taken advantage of the unprecedented opportunity which this world's war for Democracy has opened up for them through the medium of the Volunteer Medical Service Corps.

HEALTH INSTRUCTIONS THROUGH DRAFT BOARDS.

Washington, D. C., Sept. 23.—Provost Marshal General Crowder today called attention to a circular of instructions prepared by the United States Public Health Service for registrants declined in the draft because of physical disability. The circular, copies of which have been placed in all the local draft boards throughout the country, is the result of a recommendation made to General Crowder by Surgeon General Rupert Blue of the U. S. Public Health Service. The Surgeon General points out that in the first draft about one-third of the men examined were rejected for physical disabilities and that hundreds of thousands will be added as a result of the examinations to be made of the new registrants.

"It is high desirable," said Surgeon General Blue, "that the men found to be disqualified for military service by the examining physicians of the local draft

boards should receive definite instructions as to the meaning of their disabilities and that a strong appeal be made to them to correct these disabilities as far as possible. But the object of this measure is not only to reclaim men for military service or for such service as they can perform, but to lessen the burden of illness and disability among those engaged in essential industrial work. It is hoped that the instruction in this circular, which is really a primer of the physical defects of the nation, will reach far beyond the draft board and be utilized by all agencies interested in improving the public health to instruct the people with regard to their physical deficiencies and the ways and means by which they can be remedied."

According to the U. S. Public Health Service experience everywhere shows that the proportion of persons with physical impairments is considerably greater in persons between 30 and 40 than in those between 20 and 30 years of age. This waning vitality at ages over 30, so commonly accepted as inevitable, can be postponed to a large extent. In this connection, it is pointed out that 60 per cent of the physical defects found in the last draft were of a preventable or curable nature.

In addition to furnishing all the local draft boards throughout the country with a sufficient number of the circulars to supply one to each registrant rejected because of physical disability, arrangements have been made to furnish speciments of the circular to life insurance companies, fraternal organizations, labor unions, employers of labor and others who desire to reprint the circular in its present official form for wider distribution.

"The U. S. Public Health Service will be glad to furnish specimens of this circular on application and urges all organizations that can reach large groups of people to reprint and distribute the circular and thus contribute materially to the public welfare and the national defense."

The circular issued by the U. S. Public Health Service is entitled "Information for Guidance and Assistance of Registrants Disqualified for Active Military Service Because of Physical Defects." It is a four-page leaflet, containing specific information relating to the commoner causes of rejection or deferred classification, e. g. Defective Eyesight, Teeth and Disease, Feet, Underweight, Overweight, Hernia, Hemorrhoids, Varicocele, Varicose Veins, Bladder, Kidney and Urinary Disorders, Ear Trouble, Heart Affections, High Blood Pressure, Lung Trouble, Rheumatism, Venereal Disease, Alcohol, Nervous and Mental Disease, and Miscellaneous Conditions. The information is presented in simple form and has been approved by the highest medical authorities. At the end is a striking quotation from President Wilson, "It is not an Army we must shape and train for war; it is a Nation." This is followed by the following personal appeals:

"Do not go through life with handicaps that may be easily removed. Do not shorten your life, reduce your earning capacity and capacity for enjoying life, by neglecting your bodily condition."

"While other men are cheerfully facing death for the cause of democracy, do not shrink from facing a little trouble and expense to make yourself strong, health and fit."

Over a million copies of the leaflet have been sent out to the draft boards. Requests for specimen copies should be addressed to the U. S. Public Health Service, Washington, D. C.

WAR NOTES

Dr. L. W. Boyden, formerly located at Green Bay, was wounded severely in France, August 8, it was learned in a message received by relatives. He was with the 127th Infantry of the 32d Division. Lieut. Boyden joined the Medical Corps when practicing in Seymour and was assigned to the Oconto division. He went over seas in February and prior to that time was at Fort Riley and Camp MacArthur.

Major Geo. Seen of De Pere has been assigned to Camp Devens, Ayer, Mass. He will be in the surgical section of base hospital number 76.

Registrants under the draft who have been placed in group B (remediable defects) are taking advantage of the opportunity offered them by the physicians and hospitals throughout the state to have their defects corrected and made ready for service.

Captain S. E. Gavin of Fond du Lac, assigned to service in June of this year, has been promoted from battalion surgeon to chief of the surgical service of the base hospital at Camp Colt, Gettysburg, Pennsylvania. It is also reported that he has been recommended for a majority.

Dr. E. J. Knapp of Rice Lake writes from Fort Riley that he is in charge of the isolation department, consisting of six wards in which are placed all the contagious cases.

Dr. J. R. Longley of Fond du Lac, one of the first physicians from that section to volunteer, has been assigned to service in Russia.

Captain Philipp A. Fox of Milwaukee has been assigned to the Mayo Hospital, Rochester, for a six weeks course in surgery.

Dr. B. H. Holmes of Delavan has been promoted to a captaincy and assigned to Camp Custer.

Captain Emmett Mason, formerly of Eau Claire, who has been given a course in training at Rochester, has been assigned to Fort Dodge, Iowa.

Dr. M. A. Bernstein of Kenosha who has entered the service has been succeeded by Dr. A. L. Christofferson of Oshkosh.

A farewell dinner was given September 27th in the Knights of Columbus Club House, Milwaukee, for Captain T. L. Harrington who left the following week for an army training camp.

Dr. F. H. Russell of Neenah who has been taking a special course at Rochester has been promoted to a captaincy.

Major General Merritt W. Ireland has been nominated by the President to be Surgeon General for the period of four years, beginning October fourth. Vice-Major General W. C. Gorgas retired on October fifth.

Mrs. Dirk Bruins, 272 Thirty-fifth street, received a cablegram from the Danish Red Cross informing her that her husband, Maj. Dirk Bruins, had been taken prisoner by the Germans and was now in a German prison camp.

Maj. Bruins and Dr. Arthur Mitten also of Milwaukee, were members of a part of four which went to an advanced post last month, but never reached their destination.

The automobile in which they traveled was found on the roadway, but no trace of the men could be found.

Dr. Geo. M. Smith of Chippewa Falls is now stationed at Evacuation Hospital No. 34, at Camp Sheridan, Alabama, having been transferred from Camp Shelby, Miss., about ten days ago. The unit he is connected with now is an overseas unit and consists of 34 officers and 237 enlisted men as nurses, clerks, orderlies, etc. They carry 1,000 beds and 500 cots, a complete equipment of surgical instruments, dressings, medical supplies, X-ray apparatus, etc.

Dr. G. F. Kinne of Milwaukee has been discharged from service because of physical disability.

Dr. Louis M. Warfield of Milwaukee in service at Jefferson Barracks, we learn, has been recommended for a majority.

Dr. L. G. Sykes, formerly of Milwaukee, has been promoted to a captaincy. He is stationed at Camp Grant.

Word has been received of the safe arrival overseas of Maj. G. I. Hogue. Mrs. Hogue, who spent a few weeks in New York with her husband, has returned to the city and will spend the week end with her parents, Judge and Mrs. George D. Breed, of Chilton, Wis.

Reports that Capt. Archie Roosevelt, wounded several months ago in France, was in any way mentally affected by his experiences, are discountenanced by Capt. Harry B. Podlasky, Milwaukee physician stationed at the United States General Hospital No. 1, New York City, who is here for a few days.

Capt. J. C. Elsom, formerly professor of physical education at the university, and doctor in charge of corrective gymnastics, has been ordered to Fort Leavenworth, Kan., and left Madison.

Dr. Charles Gorst has received the appointment of Medical Director of Health and Sanitation in a government ship-building plant in Mobile, Alabama, where 2,500 men are employed and will begin his duties Sept. 25th. Mrs. Gorst's son, Robert Bailey, has a position in the same plant.

Students of dentistry to be enrolled in the Students' Army Training Corps under the act of congress of October, 1917, must be regular attendants upon a dental college graded either as class A or class B, according to the ruling of the war department officials.

Mrs. Dirk Bruins has received a card from her husband, Maj. Bruins, a prisoner in a German Camp. The card is dated from Mainz, Aug. 19.

It reads:

"I am getting the first possible card to you. I am a prisoner, very slightly wounded, and will soon be entirely recovered. I am being well used and there is nothing to worry about. The officers here are very kind and helpful to me. Will write as often as permitted.

Dr. C. H. Lemon has received a cablegram from the International Red Cross at Geneva, Switzerland, that Capt. Arthur Allen Mitten, reported a prisoner in a German camp, is in good health. He is at Karlsruhe.

Mrs. Mitten is motoring to Philadelphia with her father-in-law.

A clipping in a London paper sent by Maj. James R. Scott of the medical corps of the Thirty-second division, told of the capture of two American doctors who were dressing the wounds of German soldiers. The description tallied with that of Dr. Mitten and Dr. Dirk Bruins, his companion.

The government has appointed Dr. E. W. Cooney and Dr. Charles Reineck to examine the men who come to Lawrence for military training. These doctors will also look after the health of the boys until a medical officer is appointed to be stationed here.

Maj. George V. I. Brown medical corps is relieved from duty as examiner at Milwaukee upon arrival of Capt. James D. Madison, medical corps, at that place and will proceed to Washington, and report in person to the surgeon general of the army for duty in his office.

COMMISSIONS AWARDED.

Rush Godfrey, Lancaster.
W. A. Bailey, Fennimore.
W. McLaughlin, Stockbridge.
Harry Burger, Beloit.
P. J. Majerus, Sullivan.
E. L. Dalwig, Milwaukee.
W. J. Murphy, Milwaukee.
J. D. Madison, Milwaukee.
J. E. Bentley, Portage.
F. C. Haney, Watertown.
C. W. Giesen, Superior.
R. K. Lohmiller, Superior.
O. H. Foerster, Milwaukee.
R. R. Rath, Granton.

O. H. Gunther, Sheboygan.
J. F. Myre, Boyd.
C. Fidler, Milwaukee.
H. E. Schmidt, Milwaukee.
W. Yaffe, Milwaukee.
W. A. Prouty, Burlington.
J. E. Donnell, Cuba City.
H. J. Haubrick, Oshkosh.
A. J. Patek, Milwaukee.
C. O. Latham, Green Bay.
J. A. Cox, Wautoma.
J. H. Carroll, Milwaukee.
F. L. Crikelair, Green Bay.
G. W. Curless, Walworth.
V. L. Simones, La Crosse.
W. J. Waldschmidt, Fond du Lac.
H. McCabe, Milwaukee.
R. C. Westhofen, Milwaukee.
J. G. Egan, La Crosse.
F. H. Baldwin, Bloomington.
G. E. Bilstad, Cambridge.
F. B. Welch, Janesville.
C. M. Schuldt, Platteville.
Robert Carlton Faulds, Abrams.
George Thomas Hegner, Appleton.
Harry Ernest Burger, Beloit.
Winfred Merritte Johnston, Dale.
Patrick George McCabe, Fond du Lac.
Walter Conrad Roth, Franksville.
Herbert Augustus Rice, Gays Mills.
Jacob Gomber, Gillett.
Francis Peter Neis, Gilman.
Merton Rlbridge Rideout, Hortonville.
Otto Ernst August Westedt, Loganville.
Carl Wright Lockhart, Mellen.
Timothy Lewis Harrington, Milwaukee.
James Daniel Madison, Milwaukee.
Henry McCabe, Milwaukee.
William Joseph Murphy, Milwaukee.
Charles Arthur Wilske, Milwaukee.
Englebert August Ketterer, Montford.
Robert Clayton Thackeray, Racine.
Thomas Emmett Farrell, Seneca.
Frederick Josiah Hinkley, Stanberry.
Robert Eugene Doern, Stockbridge.
Peter James Majerus, Sullivan.
Victor Emanuel Ekblod, Superior.
Otto Hottinger Foerster, Milwaukee.
James Joseph Heffron, Milwaukee.
Edward Dwight Rigby, Milwaukee.
Guy Edward Armstrong, New London.
Hubert Jerome Haubrick, Oshkosh.
Lester Eastwood Beringer, Plymouth.
Gerhard Alfred Natvig, Prairie Farm.
George Armor Davis, Redmond.
William Clyde Comee, Seymour.
Walter Clarence Reineking, Wales.
Louis Henry A. Nowack, Watertown.
Richard W. Jones, Wausau.
John Austin Cox, Wautoma.
Victor Gregory Foley, Wauwatosa.
Benne Florenz Koch, Wauwatosa.
Lubin Winfred Sayles, Baraboo.
John Markley Ross, Bloom City.
Fayette Harding Baldwin, Bloomington.
William Allen Prouty, Burlington.
Guneriur Ellsworth Bilstad, Cambridge.
Albert Marion Christofferson, Colby.
Henry Cleophas Wiger, Dallas.
Frank Parker Marshall, Fond du Lac.
Herman Ferdinand Derge, Eau Claire.
Walter Guy Law, Glidden.
Alphonse DePierre, Green Bay.
Edwin Smith McNevins, Green Bay.
Simon William Murphy, Kenosha.
Frank Lyall Griswold, Mazomaine.

ORDERED INTO SERVICE.

E. A. Ketterer, Montfort, Ft. Riley.
W. J. McLaughlin, Stockbridge, Camp Grant.
E. L. Dallwig, Milwaukee, Ft. Oglethorpe.
W. J. Murphy, Milwaukee, Camp Greenleaf, Ga.
H. E. Burger, Beloit, Ft. Riley.
J. D. Madison, Milwaukee, Milwaukee.
J. C. Elson, Madison, Fort Leavenworth.
J. E. Bentley, Portage, Ft. Benj. Harrison.
C. W. Giesen, Superior, Ft. Oglethorpe.
W. C. Reincking, Wales, Ft. Riley.
O. H. Gunther, Sheboygan, Ft. Riley.
J. F. Myre, Boyd, Ft. Riley.
R. K. Lohmiller, Superior, Camp Custer.
W. E. Nelson, Kenosha, Ft. Oglethorpe.
O. H. Foerster, Milwaukee, Ft. Oglethorpe.

RECENT ORDERS ISSUED TO WISCONSIN PHYSICIANS IN SERVICE.

To Fort Oglethorpe for instruction, Capt. H. A. Rice, Gays Mills; Lieuts. G. T. Hegner, Appleton; W. C. Roth, Franksville; C. W. Lockhart, Mellen.

To Fort Riley for instruction, Lieut. V. E. Ekblad, Superior.

To Boston, Mass., Harvard Graduate School of Medicine, for instruction in orthopedics, from Camp Devens, Lieut. H. E. Bundy, Milwaukee.

To Camp Grant, Ill., Capts. R. C. Faulds, Abrams; R. P. Potter, Marshfield; Lieuts. F. P. Meis, Gilman; E. H. Townsend, Jr., New Lisbon; T. J. Sheehy, Tomah.

To Camp Sherman, Ohio, base hospital, Lieut. W. J. Winnemann, Athens.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion to Fort Riley, base hospital, Lieut. H. C. Maurer, Beloit.

To Williamsbridge, N. Y., from Camp Dix, Lieut. T. C. H. Ahelmann, Watertown.

To Azalea, N. C., Capt. E. W. Smith, Madison.

To Camp Dodge, Iowa, base hospital, Lieut. A. T. Shearer, Edgerton.

To Camp Joseph E. Johnston, Fla., base hospital, from Fort Oglethorpe, Capt. V. F. Marshall, Appleton.

To Camp McClellan, Ala., with the board examining the troops for cardiovascular diseases, from Washington, Lieut. D. H. Witte, Hartford.

To Camp Meigs for instruction, and on completion to Camp Meade, Md., from the Surgeon-General's Office, Major J. R. McDill, Milwaukee.

To Camp Pike, Ark., evacuation hospital, from Camp Sherman, Lieut. C. E. Stolz, Milwaukee; from Fort Oglethorpe, Capt. A. S. White, Rice Lake; Lieut. H. L. Garner, Rhinelander.

To Camp Sheridan, Ala., evacuation hospital, from Camp Shelby, Lieut. G. M. Smith, Chippewa Falls.

To Camp Upton, N. Y., Lieut. C. A. Wilske, Milwaukee.

To Fort Oglethorpe for instruction, Lieut. G. J. Flannagan, Kaukauna.

To report to the commanding general, Philippine Department, from Camp Travis, Lieut. C. D. Martin, Wauwatosa.

To Rochester, Minn., Mayo Clinic, for instruction, and on completion to his proper station, from Camp Grant, Capt. P. A. Fox, Milwaukee.

To Washington, D. C., Surgeon-General's Office, from Milwaukee, Major G. V. I. Brown, Milwaukee.

To Camp Custer, Mich., Lieut. P. J. Majerus, Sullivan.

To Camp Lee, Va., Capt. T. E. Farrell, Seneca.

To Camp Sherman, Ohio, Capt. J. Gomber, Gillett.

To Fort Oglethorpe for instruction, Lieuts. O. E. A. Westedt, Loganville; W. J. Murphy, Milwaukee.

To Fort Riley for instruction, Capt. E. A. Ketterer, Montford; Lieut. H. E. Burger, Beloit.

To Fort Sheridan, Ill., Capt. T. L. Harrington, Milwaukee.

To Milwaukee, Wis., as examiner, Capt. J. D. Madison, Milwaukee.

To Camp Custer, Mich., base hospital, from Camp Greene, Lieut. E. A. Gatterdam, Wauwatosa.

To Camp Hancock, Ga., as orthopedic surgeon, from Fort Oglethorpe, Capt. E. L. Bolton, Chilton.

To Camp MacArthur, Texas, or orthopedic surgeon, from Fort Oglethorpe, Lieut. J. D. Gillis, Wauwatosa.

To Camp Sherman, Ohio, evacuation hospital, from Camp Zachary Taylor, Lieut. A. J. Looze, Brodhead.

To Camp Travis, Texas, from Southern Department, Lieut. O. F. Partridge, Mattoon.

To Fort Benjamin Harrison, as orthopedic surgeon, from Central Department, Lieut. J. E. Bentley, Portage.

To Morrison, Va., from Lee Hall, Lieut. J. D. Nelson, Milwaukee.

To Camp Custer, Mich., Capt. W. G. Law, Glidden; Lieuts. G. E. Armstrong, New London; R. K. Lohmiller, Superior; L. H. A. Nowack, Watertown.

To Camp Grant, Ill., Lieuts. H. C. Wiger, Dallas; W. J. McLaughlin, Stockbridge.

To Fort Oglethorpe for instruction, Lieut. A. M. Foster, Kaukauna.

To Fort Riley for instruction, Capt. C. F. Myre, Chippewa Falls; Lieut. W. C. Reineking, Markesan.

ABSTRACTS

THYROID SURGERY. C. H. Mayo, Rochester, Minn. (*Journal A. M. A.*, Aug. 31, 1918), reviews the surgery of the thyroid and describes the development of the organ. The earliest surgery was followed by high mortality, until the period of antisepsis and asepsis developed safer methods. The thyroid is one of the most important glands of the body, though our knowledge of its functions is still incomplete. The work of Plummer and Kendall, however, is mentioned by Mayo as a great advance. The discovery of a thyrotoxin by Kendall and the subsequent researches of Plummer show that this thyrotoxin has a controlling influence on the energy production in the animal organism, and is the most active factor in the metabolism. Exophthalmic goiter or hyperthyroidism develops an enormous increase in the metabolic rate and thyroidectomy, complete or partial, in most cases will reduce metabolism to nearly normal. There is still much lacking in our knowledge of the activating agent causing hyperplasia of the gland, but Mayo thinks the discovery of this is probable. The simple goiters of adolescence are common, and do not call for surgery unless they give trouble or are too unsightly. Later in life the degenerations of the goiter are likely to occur. The older the person when goiter develops, the more quickly must degeneration occur. Simple types of goiter or adenomas often grow to enormous size and may project down into the chest. Mayo says that "the dangers incident to the operation are the condition of the patient, as in exophthalmic and thyrotoxic goiters, and those due strictly to the operation, as loss of blood, secondary hemorrhage, interference with respiration, injury to the recurrent nerves and to the parathyroids. The parathyroids and the recurrent nerve should be guarded in simple goiter by leaving the posterior part of each lobe of the gland on the posterior capsule, and by care in the use of forceps, and care in suturing the remainder of the gland and in the ligation of its vessels. Laryngoscopic examination should be made before operation to disclose the condition and the enervation of the vocal cords, as paresis or paralysis of an abductor or adductor may be present with but little change in the voice, and especially as unilateral tumors on the right side may produce paralysis of the left recurrent nerves, and surgical injury to the right side may result in total loss of voice. The parathyroids controlling the nitrogen elimination should be preserved as a guard against tetany. Local anesthesia may be used in special cases, but ether and local anesthesia are used in most instances. The best method of approach is through a low collar incision. The sternothyroid and sternohyoid muscles should be cut high and resutured if they interfere with the surgical exposure of the gland; greater experience seldom requires their division. The isthmus should be removed and double resection is the operation of choice in simple goiter, while in the exophthalmic type, removal of the larger lobe, isthmus and part of the remaining lobe is the most common procedure. Drainage is instituted for twenty-four hours in the majority of cases, although the substernal goiter, the cavity of which does not immediately become obliterated by intrathoracic pressure, should not be drained longer than a few hours, at most, to retain a blood clot for organization; otherwise drainage in such cavities is indefinite." Recurrence may take place from not removing a portion of the gland in which the morbid conditions exist. Failure to judge the possibility of this is bound to occur in a small proportion of cases, but the cures by operation are practically 70 per cent. Plummer's work on metabolism taken with Kendall's on the chemistry of physiologic action explains many questions of recurrence that were formerly thought to indicate that surgery was not warranted. The results obtained by operation approximate what should be expected after the work of Plummer and Kendall, which Mayo says he considers at this time the most important advance made in medicine of the chemistry of life.

TUBERCULOSIS EXAMINATIONS IN THE ARMY. F. B. Trudeau (Saranac Lake, N. Y.), New Haven, Conn. (*Journal A. M. A.*, Sept. 7, 1918), reports his experience in examinations for tuberculosis in training camps at Plattsburg and Camp Devens. He states the lessons that have been taught by experience in this work, namely, the grouping of cases in the history taking as well as in the physical examination itself. He holds that a tuberculosis examining board should occupy only six hours of their time each day in the work, and the number of pulmonary examinations for each medical officer should be at least seventy-five, but should not exceed 100. The work is so intensive that it is tiring on both mind and body, therefore, the above time limit is suggested. The routine taking of histories is not of much value, but the

one most important procedure in the pulmonary examination is auscultation for râles after cough, performed preferably and if possible at the end of respiration. The disability board to which rejections are referred should consist of three members, the president of the examining board and two others chosen by him from the members of the board. It should have the final disposition of all lung cases referred to it. The average incidence of tuberculosis in the cases examined was 0.5 per cent., slightly lower than in the reserve officers, slightly higher in the National Army, and just this average in the Regular Army.

THE ARMY TUBERCULOSIS EXAMINER. C. L. Wheaton (Chicago), Camp Grant, Rockford, Ill. (*Journal A. M. A.*, Sept. 7, 1918), reports his observations as a tuberculosis examiner of recruits or drafted men. In military practice it is of the utmost importance to determine whether a man has tuberculosis or not, and the author goes over the details of the signs by which it can be detected, and the percentages of cases observed, and refers also to the figures reported from France and the statistics of tuberculosis in Chicago. The methods of eradicating tuberculosis in the army are grouped by him under four headings as follows: "1. Removal of those predisposing factors tending to lower the physiologic resistance of the individual, that is, bad housing, overcrowded, poorly lighted and badly ventilated tenements, inadequate and poor food supply, and insanitary conditions in general. 2. Removal of foci of infection, by hospitalization and segregation of open cases so far as practicable. 3. Effecting a cure of incipient closed cases at a time when this is possible and before there is softening of the lung tissue. 4. Eradication of bovine tuberculosis and more widespread knowledge of the dangers resulting from the consumption of meat and milk from tuberculous cattle, notwithstanding the fact that the bovine bacillus is less virulent than the human bacillus for man."

USE OF DICHLORAMIN-T. W. E. Lee and W. H. Turner, Philadelphia (*Journal A. M. A.*, Sept. 14, 1918), say that the experience of American surgeons in this war agrees with that of other surgeons of France and England, namely, that chlorin preparations have proved superior to all other germicides in military and other surgery. According to Dakin's views the germicidal action of all chlorin preparations depends on substances resulting from the chemical reactions between the chlorin and the proteins of the tissues and exudates in infected wounds, which substances are known as chloramins. These chloramins, unlike chlorin, are not destructive to the tissues, and may be used in solutions as strong as 10 per cent, and, therefore, it is not necessary to use the very weak concentrations, which require frequent applications, most essential when chlorin solutions are used. The author refers to the commission appointed at the Boston meeting of the American Surgical Association in June, 1917, to investigate the clinical value of dichloramin-T, of which he was a member, and quotes the concluding paragraph of their first report stating the qualities of a proper germicide. These are stated by him now in more detail. The irritation that accompanies the application of most germicides, limiting their use and governing their permissible concentrations, is negligible with dichloramin-T. After fifteen months' work the authors have arrived at the following conclusions: "1. The use of dichloramin-T has definitely improved the results we have been able to obtain in the primary closure of traumatic wounds of the soft tissues, bones and joints. 2. In the treatment of superficial accessible surgical infections the use of dichloramin-T has uniformly given us better results than any other germicide we have employed, and the method of its application is simpler and the dressings are more economical than with any of the other chlorin agents. 3. The best results with dichloramin-T can be obtained only when actual chemical contact of the germicide with the infecting organism is maintained. To maintain such contact in superficial surgical infections is a simple matter, and in the first few months of the work a satisfactory technic for this class of wounds was developed. In deep and inaccessible infections the problem is more difficult, and the greater part of these fifteen months has been devoted to this aspect. 4. Our confidence in the germicidal value of dichloramin-T has so developed that when it does not control a surgical infection we believe that the chemical contact has not been maintained, the mass of the germicide employed has not been sufficient, or adequate surgical treatment has not been given. 5. The striking detoxicating effect of the chlorin group of germicides, which has become common knowledge through the general use of Dakin's hypochlorite solution, is just as satisfactorily exhibited with dichloramin-T."

WAR SURGERY. J. J. Moorhead (New York), France (*Journal A. M. M.*, Aug. 31, 1918), gives an account of operations performed on 132 patients during the recent spring offensive in the present war. The summary is detailed and his conclusions in substance are as follows: No patient should be operated on until thoroughly warmed unless bleeding is uncontrollable. Patients coming in with a tourniquet, with or without severing of main vessels, are bad risks, as gas gangrene is likely to have developed, and the wound in such cases should never be closed. Any unusual rise of temperature or pulse, especially if associated with restlessness, calls for immediate attention on account of the risk of gas gangrene. Persisting high temperature and pulse almost always means that the wound is not doing well, unless pneumonia or soem other acute systemic condition can be positively shown. Freedom from subsequent infection is directly in proportion to the removal of damaged tissue. Persisting shock usually indicates hemorrhage. Ether has shown an unusual efficacy when employed to lavage wounds during and after operation, especially when muscle tissue is much involved. Post-operative dressings should be moist for the first few days at least. Drainage will cause infection if used for more than forty-eight hours, especially if rubber tubing is employed in parts subjected to movement, such as the abdomen or chest.

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ORGANIZED 1841

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The Wisconsin Medical Journal, Official Publication

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Wood	Ed. Hongen, Grand Rapids	W. M. Ruckle, Grand Rapids.

SOCIETY PROCEEDINGS

MILWAUKEE MEDICAL SOCIETY

The regular monthly meeting of the Milwaukee County Medical Society was held at the Hotel Wisconsin, Friday evening, Sept. 13. The following program was presented:

"Renal Calculi," by Dr. A. E. Fletcher.

Discussion on X-ray findings by J. S. Jansen.

The following were elected alternates to the House of Delegates of the State Society: Oscar Lotz, J. A. Purtell, C. M. Echols, R. G. Sayle, C. H. Lemon, W. E. Grove, and L. Boorse.

DANIEL HOPKINSON M. D.,
Secretary.

GRANT COUNTY

The Grant County Medical Society held a meeting at Boscobel, Thursday, August 29th. The attendance was smaller than is usual at this place, as so many of our members are in active service. But it was an enthusiastic gathering. Each one was making an effort to see how best he could serve his country or community. The subjects Tetanus and Infantile Paralysis were discussed and interesting cases reported by Drs. M. W. Randall, J. C. Doolittle, J. C. Betz, E. H. Spiegelberg and M. A. Bailey. Some subjects of interest to the medical profession relating to the war were presented and discussed.

J. C. BETZ, M. D.,
Secretary.

RACINE COUNTY.

The regular meeting of the Racine County Medical Society for June 27, 1918, was held at the Lakeside Hotel, Brown's Lake, Racine County, Wis., at 1:00 P. M.

The meeting was called to order by the president, Dr. G. W. Nott.

Reading of the minutes of the previous meeting was dispensed, owing to lack of time.

Dr. A. M. Foster, who is in service, and Dr. S. H. Sauter of Racine, were duly elected members of the society.

Applications of Drs. Chresten Olsen and F. B. Marek, both of Racine, were read and same referred to the Board of Censors.

Dr. Leigh F. Watson, Chicago, addressed the meeting on the subject of "Treatment of Goiter." The lecture was illustrated. The attendance was good.

SUSAN JONES, M. D.,
Secretary.

NEWS ITEMS AND PERSONALS.

Dr. G. W. Crosby of Sheboygan, while en route to Lundington, Michigan, was stricken with paralysis in Chicago. This is the fourth attack he has had and his condition is critical as we go to press.

Dr. Geo. C. Bock has been appointed professor of physiological chemistry at Marquette University School of Medicine to succeed Dr. Farmer who has left to take this chair at the Northwestern. Dr. Bock has the degree of chemical engineer from the University of Vienna and a Ph. D. from Cornell. For the past year he has been first assistant to Professor Benedict of Cornell.

Dr. V. A. Chapman of Milwaukee has been called to Boston by Surgeon General Blue to aid in the fight against influenza.

The hospital situation in Milwaukee is critical. Milwaukee has fewer hospitals than any other city of its size and the recent epidemic has taxed the capacity of every institution caring for the sick.

Miss Zelma Gnagi, daughter of Dr. and Mrs. W. B. Gnagi of Monroe, was married recently to Lloyd Helms of St. Paul, Minnesota.

Milwaukee already is preparing to care for invalided soldiers sent here by the government. In compliance with a government request the local hospitals are submitting reports to the war department at Washington giving a detailed list of the number of men that can be cared for. Seven of the hospitals have prepared their lists and will forward them to Washington.

The building fund of the Milwaukee Maternity hospital has been started with a pledge of $2,500 from Mrs. Charles F. Norris. Other pledges include: Frank Glode, $1,000; Robert T. Hazelwood, $1,000; Dr. Edward S. Loge, $1,000; Dr. L. J. Foley, $1,000; Dr. and Mrs. G. A Hipke, $1,000.

Dr. Arthur T. Holbrook of Milwaukee has recently returned from a hunting trip in Alaska. His party visited the famous Cassiair Mountain range and were successful in securing a good bag of game.

It was voted at the first regular meeting of the fall session of the board of directors of the Milwaukee Maternity Hospital Association, which was held at the City Club to change the name of the hospital to Milwaukee Maternity and General Hospital.

This step was necessary in order that the Training school for nurses might remain on the accredited list without being compelled to affiliate with another school.

The hospital is now ready to receive applicants from young women who wish to take up training.

Thomas S. Morris, secretary of the Madison General hospital board, has been elected president of the board, succeeding Frank D. Winkley, resigned. N. J. Frey, of the Wisconsin Life Insurance Company was elected Secretary; Oscar Miller was elected member of the board to fill a vacancy and Miss Anderson was appointed to represent the Attic Angels.

Dr. J. Noer of Stoughton has sold his residence, will dispose of his practice and in the near future leave for California where he and his family will make their future home. The move is made on account of the health of the doctor's daughter.

Mrs. H. J. Dernehl, 591 Stowell avenue, was elected president of the Wisconsin Association of Graduate Nurses, which concluded its ninth annual convention at the Milwaukee County Nurses' Club. As president, Mrs. Dernehl also becomes a delegate to the State Federation of Women's Clubs, whose convention takes place in Eau Claire Oct. 10, 11 and 12. Miss Mathild Krueger, of Neenah, is the other delegate to this convention. The following officers and directors were elected:

First vice president, Mrs. Millicent Northway, Kenosha; second vice president, Miss Amelia Olson, Eau Claire; secretary, Mrs. Kate Kohlsaat, Milwaukee; treasurer, Miss Margaret Pakenham, Milwaukee.

Plans are under way to endeavor to obtain legislative action this winter that will authorize a four year medical school at the University of Wisconsin. At the present time the medical course at the university is a two-year course and is therefore simply preparatory course here and then go to Rush Medical, John Hopkins and other medical schools.

A series of noon health talks will be given at Milwaukee factories and manufactories and manufacturing plants in the next few weeks, under the direction of the welfare department of the Council of Defense.

Dr. D. N. Walters of Fond du Lac has removed his office and is now associated with the Fond du Lac Clinic.

The Evangelical churches of Milwaukee held a joint meeting September 16 to celebrate the anniversary of the founding of the new Evangelical Deaconess Hospital at 1518 Grand Avenue. The hospital can care for fifty-five patients and has been filled to capacity from the day of opening.

Dr. A. J. Morse has removed from Oakfield and taken over the practice of Dr. J. S. Foat of Ripon who is in the service.

Dr. W. B. Peck, president of the Tri-State Medical Society, according to Freeport papers, is under investigation as having falsely returned to the Local Board his age. He is charged with not having registered though within the draft age.

Members of the Kenosha County Medical Society attended in a body the First Congregational Church at Kenosha, September 20, to attend a lecture given by Dr. J. R. Pennington of Chicago.

The Milwaukee Medical Society has asked the common council to defer action on a recommendation of its judiciary committee to prohibit the parking of automobiles for more than two hours on any street or alley in the city.

Occupational therapy will shortly be established in the Milwaukee County Hospital for mental diseases.

The Marquette University one million dollar endowment fund for the development of its medical school has been raised. An outright gift of from four to five million dollars is expected by the college authorities if plans for the development of the college are approved this month by Dr. Henry S. Pritchett, president of the foundation.

The Surgeon General of the U. S. Public Health Service has just issued a publication dealing with Spanish Influenza, which contains all known available information regarding this disease. Simple methods relative to its prevention, manner of spread, and care of patients, are also given. Readers may obtain copies of this pamphlet free of charge by writing to the "Surgeon General, U. S. Public Health Service, Washington, D. C."

MARRIAGES

Lieut. F. M. Harris, M. C., formerly of Fond du Lac, and Miss Margaret Trimm, also of Fond du Lac, were married in New York City August 27. Doctor Harris is assigned to a base hospital in New Haven, Connecticut.

DEATHS

Dr. A. F. McKay, formerly of Superior, Wisconsin, died at Pueblo, Colorado, July 24, at the age of sixty-eight years. He had been in the west about twenty years.

Dr. Louis Falge of Manitowoc, a member of the Manitowoc County and Wisconsin State Medical Societies, died at the Manitowoc Hospital at four o'clock Sunday afternoon, August 4. Doctor Falge was 56 years of age and was numbered among the county's most successful and able medical practitioners. He was born in Bohemia in 1861 and emigrated to America when a lad of eight. His family settled in Manitowoc and Dr. Falge attended the common schools in that city. He graduated from the University of Wisconsin in 1884 and from Rush Medical in 1887. After graduating, he practiced at Cato and Reedsville, locating in Manitowoc in 1907. He had served as physician at the County Asylum, as coroner of the county and as secretary of his County Medical Society.

Dr. N. C. Evans of Mt. Horeb died at his home, August 21, after a long illness. Dr. Evans had reached the age of 62. He was a former member of the Assembly and had represented Mt. Horeb on the Dane county board for several years. He was a member of the Dane County and State Medical Society.

Dr. Walter Kempster died at his home in Milwaukee after a long illness, August 21. He was born in London in 1841 and came to America at an early age. He served with the twelfth New York regiment of volunteer infantry throughout the Civil War. From 1867 to 1873 Doctor Kempster was assistant physician to the New York State Asylum for the Insane and from 1873 to 1884 was superintendent of the Northern Hospital

for the Insane at Oshkosh. Doctor Kempster moved to Milwaukee permanently in 1890. A year later he received an appointment as special commissioner by the U. S. Government to visit Europe and investigate the question of emigration to this country. Dr. Kempster specialized in psychiatry and was identified with many important trials. He was called as an expert in the case of Charles J. Guiteau, assassin of president Garfield.

Dr. A. V. Wells of Fennimore, Wisconsin, died August 21, 1918. While a graduate physician, he had never practiced medicine in Wisconsin, and had devoted his life to farming in Grant County.

Dr. Horace L. Kutchin, a former Fond du Lac resident, died at Columbus, Ohio, September 3. Doctor Kutchin was born at Green Lake and received his education at Lawrence College and Rush Medical. After graduating, he located in Columbus.

Dr. Karl Wagner of Milwaukee died September first while on his return from a trip to Detroit, Michigan. He was 54 years of age. He was a leader of social activities in Milwaukee and had devoted much of his life to the cause of the Polish race. He was a member of the Milwaukee County and Wisconsin State Medical Societies.

Dr. F. B. Hoermann of Watertown died at a Milwaukee hospital September 16. He was 74 years of age and had practiced in Watertown since 1881.

Mrs. H. L. Garner, wife of Dr. H. L. Garner of Rhinelander, died at St. Mary's Hospital, August 19, 1918. Mrs. Garner was taken sick but a week before her death while visiting the doctor who is attached to a military training camp in Georgia.

TRANSPORT SPLINTS. R. B. Osgood (Boston), Washington, D. C. (*Journal A. M. A.*, Aug. 31, 1918), describes the transport splints used in the American Army at the front. As early as August, 1917, it became evident to American surgeons serving in British hospitals that entirely satisfactory splinting for transport could be accomplished with a small number of splints of simple pattern. Attention was called to this fact and General Bradley, the chief surgeon of the American army in France, and General Pershing appointed a board to standardize the splints according to this finding of experience. The board produced a manual which was published by the American Red Cross. The transport splints recommended are described at some length in this article as well as the types of injury for which they are applicable. The division of orthopedic surgery under Lieutenant-Colonels Goldthwait and Allison has been given charge of the splinting at the front, and the details of the drill of the operators are described. It will be a satisfaction to know that the splinting and care of the injured is as promptly done in the American army as in any other, and perhaps a little earlier.

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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STREPTOCOCCUS SORE THROAT AND PNEUMONIA.

Septic Sore Throat.

Septic sore throat, otherwise known as epidemic tonsillitis, is a severe communicable disease. It has been separated from simple tonsillitis, and has been by many always connected with the milk supply. The degree of severity and the prevalence often determines whether the diagnosis is septic sore throat or simple tonsilitis. The bacteriological diagnosis is in most instances ignored, and the disease is rarely reported.

The bacteria involved in this disease and the modes of transmission have been very thoroughly studied by many. Smillie, however, following the studies of Smith and Brown on the hemolytic streptococcus has given an excellent exposition of this organism with relation to septic sore throat, and its modes of transmission.

He reports an epidemic which occurred in Dorchester, Mass., which was milk borne, and summarizes the most essential information gained from his study of this epidemic as follows: The beta hemolytic streptococcus from the throats of patients ill with septic sore throat was identical with that isolated from the throats of the dairymen, and from Pond's milk, which had been used by almost 90% of those who were ill.

With reference to milk borne epidemics of this disease, attention should be called to the paper of Mathers in which the following summary is found.

Hemolytic streptococci of human origin produce mastitis in cows, when injected directly into the milk duct. On the other hand virulent hemolytic streptococci may grow and multiply in the milk duct of a cow without causing any visible change in the udder. Cows so infected may continue to shed these bacteria for a long time.

It is obvious that the infection of cows has a previous origin. In this relation the work of Smith and Brown, who distinguished between the human hemolytic streptococcus, beta hemloytic type, and the streptococcus of garget, and the recent reports from the different cantonments in-

dicates that the chief source of this infection is from the human carrier; from these, of course, the milk may be infected directly, or the milk ducts of the cows may be infected.

Septic sore throat in the sense that any sore throat produced by a streptococcus giving the beta type of hemolysis is a septic sore throat may be severe, moderate or mild. Smillie reports an epidemic, which occurred in a boarding house (K). As a result of this study he makes the following statement: The same strain of the beta hemolytic streptococcus was isolated from severe, moderate, and mild cases of septic sore throat at the boarding school, K. The beta hemolytic streptococcus may also be associated with sporadic cases of tonsillitis, that is, sporadic cases of septic sore throat do occur.

The importance of the convalescent carrier is pointed out clearly in the paper of Smillie. He says: "In 100 average throat swabs only one (1) showed the beta hemolytic streptococcus. This organism may be found in the throat of an individual three months or more after an attack of septic sore throat. Such a carrier may be the source of infection for others. However, the greater proportion of cases of septic sore throat do not harbor the organisms for a long time after recovery."

Pneumonia.

The cause of pneumonia has been ascribed to many bacteria each one of which was claimed to be the specific cause. We have known for some time, however, that the typical lobar pneumonia is usually accompanied by a predominence of pneumococci in the sputum, and that pneumonias can be produced by a variety of bacteria. The work of Avery, Chickering, Cole and Dochez has added much to our knowledge concerning lobar pneumonia, and the characteristics of the pneumococcus. They have by morphological, cultural and other biological characteristics divided the group of pneumococci into three distinct types and have classified the organisms which may produce pneumonia into four classes. The first three are the specific types of pneumococci and the last is a heterogeneous group of organisms, which is composed of unclassified pneumococci and various other organisms. The frequency with which organisms of the different groups occurred in 454 cases of lobar pneumonia studied by them was:

Pneumococcus types		*Incidence* Per cent
I	151	33.3
II	133	29.3
II Atypical	19	4.2
III	59	13.0
IV	92	20.3

Laboratory method for the prompt differentiation of these types from pneumonic sputa has been devised when the specimens are properly collected and sent immediately to a laboratory, and a serum which is potent in the treatment of the type I infection has been produced at the Rockefeller Institute and is now being put on the market by some firms.

Epidemiology.

The mode of transmission is of course of great significance as concerns the prevention of the disease. The presumption has been very general because of the occurrence in the mouth of an organism, which has until now been indistinguishable from the pneumococcus, that pneumonia occurs as an auto-infection, and that the incidence of the disease is determined by variation in susceptibility brought about by exposure and other causes. At the Hospital of the Rockefeller Institute studies were carried out to determine if the variation of susceptibility offers the whole explanation of the occurrence of pneumonia or if exposure to healthy carriers and pneumonia patients does not play a considerable part. Their studies led to the conclusion that those pneumococci types commonly found in the mouth secretion of normal individuals gives rise to a minority of the cases of lobar pneumonia. Types I and II cause a majority of the cases, are of high virulence for human beings and are seldom or never found in the mouth secretions of normal individuals, who have not been in intimate contact with cases of lobar pneumonia.

THE MILWAUKEE PLAN.

The Milwaukee experiment in the organization of Red Cross Home Service committees in the various communities under the jurisdiction of the central chapters is of interest to the entire state because of the probability that it will be used as a

demonstration on which to model similar organization work in other counties.

The Milwaukee chapter of the Red Cross has jurisdiction over four counties, Milwaukee, Washington, Waukesha, and Ozaukee. Until recently all home service work was done from Milwaukee, which has a well organized department for this work.

Under the working agreement between the Red Cross and the anti-tuberculosis associations in the middle west district, the two organizations have each assumed a definite responsibility in the care of tuberculous soldiers and have adopted programs designed to bring about a close co-operation between the two. In Wisconsin, this program is being worked out along lines which are designed to eliminate duplication, unnecessary red tape, and the danger which often attends a divided responsibility.

When the Milwaukee chapter of the Red Cross decided to organize local home service committees in the territory under its jurisdiction and engaged Miss Evelyn Johnson to have charge of the work, the Wisconsin Anti-Tuberculosis association took advantage of the opportunity to "try out" the program which is in mind for the entire state and made arrangements by which Miss Johnson serves as representative of both the anti-tuberculosis association and the Red Cross in the work which she is doing. In this way each home service committee is in close touch with the resources of the anti-tuberculosis association and has the aid of its special department in the handling of individual cases of tuberculosis.

In four communities, West Bend, Schlesingerville, Hartford, and Oconomowoc, the home service committee has assumed the responsibility of looking after draft rejects as well as discharged soldiers, realizing that the work is all part of the same big problem. The Milwaukee home service department has employed a visiting nurse for its tuberculosis work and she is working in close co-operation with the City Health Department. The health department nurses look after the draft rejects.

Great care is being exercised in securing the right people for these local committees and no committee is organized in any community until a woman is found to take charge of the work who will take the special training course to fit herself for it. She takes this training either at Milwaukee or Chicago and then serves as secretary of the committee, pledging herself to give two or three hours a day to the work. A physician, a lawyer, a member of the draft board, a business man, and two women generally make up the personnel of the committee. Volunteer assistants work under the supervision of the secretary.

TUBERCULOSIS AS A RED CROSS PROBLEM.

Home service sections of the Red Cross are learning by experience the magnitude of the tuberculosis problem in Wisconsin. Official records of soldiers discharged from the United States army received by the Wisconsin Anti-Tuberculosis association from the Surgeon General's office now show a total of 563 for this state and no reports have as yet been received from the Surgeon General of the Navy. With a large number of draft boards still unheard from, the state association has an official report of 1,163 men rejected by draft boards because of tuberculosis. This number will be materially increased when the remaining boards make their report. At a conservative estimate, therefore, there are over 2,000 known cases among young men between 21 and 31 years of age and this fact is made the more significant by the further one that in the great majority of cases the presence of the disease was unsuspected prior to the military medical examination.

Through the special service department organized by the Wisconsin Anti-Tuberculosis association to deal with this problem and directed by Dr. Oscar Lotz, vice president of the State Medical Society, every one of these men who can be located is being reached personally with literature and offers of counsel and assistance in securing sanatorium care. The association is now issuing a series of special booklets written primarily for these men but with a view also to arousing the fighting spirit in other Wisconsin men and women who have been wounded by tuberculosis. In Milwaukee, Waukesha, Washington and Ozaukee counties, the association has combined forces with the Milwaukee chapter of the Red Cross in an organization experiment which will doubtless furnish the basis for a state program under which local home service committees will be organized with special reference to dealing with the tuber-

culosis in every community which is willing to assume the responsibility and to provide a trained worker. In Milwaukee and the adjoining counties this organization program is being worked out under the personal supervision of Miss Evelyn Johnson, for some time past the efficient secretary of the Central Council of Social Agencies and a woman admirably fitted by personal qualities, training and experience for the large service which she has undertaken under the joint auspices of the state anti-tuberculosis association and the Milwaukee chapter of the Red Cross.

Reaching the individual soldier and rejected man is but a detail, however, in the larger program which must be speeded up if Wisconsin is to prove equal to the tremendous task of caring for these men properly after they have been reached and for the other cases of tuberculosis, known and unknown, of whose presence in the civilian population the large number of war-revealed cases is striking indication. The state association therefore sees in its official record of disqualified men far more than a card index of nearly 2,000 individual cases and believes that its largest work lies in making the people of Wisconsin see in them also an unanswerable argument for the erection of more sanatoria, for the establishment of tuberculosis clinics in all parts of the state, and for an aggressively intensified campaign against tuberculosis.

INITIATIVE.

The world bestows its big prizes, both in money and honors, for but one thing.

And that is Initiative?

What is Initiative?

I'll tell you: It is doing the right thing without being told.

But next to doing the thing without being told is to do it when you are told once. That is to say, carry the Message to Garcia: those who can carry a message get high honors, but their pay is not always in proportion.

Next, there are those who never do a thing until they are told twice: such get no honors and small pay.

Next, there are those who do the right thing only when necessity kicks them from behind, and these get indifference instead of honors, and a pittance for pay. This kind spends most of its time polishing a bench with a hard-luck story.

Then, still lower down in the scale than this, we have the fellow who will not do the right thing even when some one goes along to show him how and stays to see that he does it: he is always out of a job, and receives the contempt he deserves, unless he happens to have a rich Pa, in which case Destiny patiently awaits around the corner with a stuffed club.

To which class do you belong?—*Elbert Hubbard.*

IF—

If you can keep your head when all about you
  Are losing theirs, and blaming it on you;
If you can trust yourself when all men doubt you,
  But make allowance for their doubting, too;
If you can wait, and not be tired by waiting,
  Or, being lied about, don't deal in lies,
Or, being hated, don't give way to hating,
  And, yet, don't look too good, nor talk too wise.

If you can dream—and make dreams your master;
  If you can think—and not make thoughts your aim;
If you can meet with Triumph and Disaster—
  And treat these two imposters just the same;
If you can bear to hear the truth you've spoken
  Twisted by knaves to make a trap for fools,
Or watch the things you've given your life to, broken,
  And stoop, and build them up with worn-out tools.

If you can make one heap of all your winnings
  And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
  And never breathe a word about your loss:
If you can force your heart, and nerve, and sinew,
  To serve your turn—long after they are gone,
And so hold on when there is nothing in you
  Except the Will which says to them: "Hold ON!"

If you can walk with crowds and keep your virtue,
  Or walk with kings—nor lose the common touch,
If neither foes nor loving friends can hurt you,
  If all men count with you—but none too much;
If you can fill the unforgiving minute
  With sixty seconds' worth of distance run,
Yours is the earth, and everything that's in it,
  And—what is more—you'll be A Man, my son!

—*Rudyard Kipling.*

JUST "HOLD YOUR HORSES."

"Keep your temper, gentle sir."
  Writes the manufacturer.
"Though your goods may be overdue
  For a month, or maybe two.
  We can't help it. Please don't swear!
  Labor's scarce, material's rare,
  Harry drafted, so is Bill;
  All our work is now uphill.
  So your order, we're afraid,
  May be still a bit delayed.
  Still, you'll get it, don't be vexed;
  Maybe this week, maybe next.
  Keep on hoping. Don't say die;
  Things will straighten by-and-by."

—*Selected.*

4 Useful Products

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Chymogen precipitates the casein in small flocculent particles which are easily reached and digested. Full directions on request.

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½cc for obstetrical. 1cc for surgical use.

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BOOK REVIEWS

MILITARY SURGERY OF THE ZONE OF ADVANCE. By George de Tarnowsky, M. D., F. A. C. S., Surgeon to Cook County and Ravenswood hospitals. 333 pages, illustrated. Lea & Febiger. 1918. $1.50.

This is Number 7 of the popular medical war manuals of Lea & Febiger. It will be remembered they are authorized by the Secretary of War and are under the supervision of the Surgeon General and the Council of National Defense. The author explains this is not intended as a text book on military surgery but rather a resume of the treatment of war wounds, the result of painfully acquired experiences on the western front during the past three years. It is written for the medical officer who suddenly finds himself confronted with a class of injuries new to him. This little work covers a large variety of subjects, a few of which may be mentioned to indicate the ground covered: First Aid Station zone of advance. Projectiles, Bacteriology of War Wounds, several chapters on wounds, tetanus, gas bacillus, gangrene, several chapters on wounds of special parts, fractures, burns, gas poisoning, trench foot, Carel-Dakin technique, etc. This is a worthy successor to the other members of this series published. Any and all of them are almost necessary to the new medical officer.

THE MEDICAL CLINICS OF NORTH AMERICA. Volume 1, Number 6. (The Southern Number, May, 1918.) Octavo of 224 pages, 35 illustrations. W. B. Saunders Company, Philadelphia and London. 1918. Published Bimonthly. Price per year: Paper, $10.00; Cloth, $14.00.

This is the index number to Volume One of this series of medical clinics and completes a most valuable series of clinic reports. Of special interest in this number are the sections on Nephropathies, McElroy, Memphis; Pneumonias and Typhoid, Bell, New Orleans; Artificial Pneumothorax, by Monor, Ashville; Malaria, Bass, New Orleans; Hodgkin's by Gibbs, Columbia, and Headaches by Monroe of Charlotte. All contributions to this number are from southern clinicians and a most complete index concludes the publication of this series. To the general practitioner, unable to leave his work to attend clinics away, this series has been of such a quality as to insure him of a splendid investment in subscribing for the next.

THE COMPOSITION OF CERTAIN PATENT AND PROPRIETARY MEDICINES. Compiled by John Phillips Street, Chemist in charge of Analytical Laboratory, Connecticut Agricultural Experiment Station. 274 pages; more than 2500 remedies; over 3100 analyses. American Medical Association, 535 North Dearborn St., Chicago. Cloth, $1.25 postpaid.

During the past few years hundreds of "patent" and proprietary medicines have been analyzed with the object of giving the public information that would be of vital interest to it. This work has been done by federal and state officials and especially by the chemists of the American Medical Association. The information, unfortunately, has been scattered through many publications and, for this reason, has not been easily accessible either to the public or to officials. The purpose of Mr. Street's compilation is to remedy this difficulty, in a measure, by bringing together in one work an accurate record of published analyses. The book contains analyses (one or more) of over 2.500 proprietary medicines, including the most widely used and extensively advertised products offered to the American public. The analyses are published without comment and without prejudice and the compact form in which they are presented should prove of great usefulness to the physician, the pharmacist, the inspection official and the intelligent layman.

THE WASSERMANN TEST. By Chas. F. Craig, A. M., M. D., Lieut. Colonel M. C., U. S. A., Commanding Officer, Department Laboratory, Ft. Leavenworth. C. V. Mosby Company, St. Louis. 1918.

This is an illustrated volume of 239 pages, based on the personal experiences gained from ten years of personal use of this test in the diagnosis and as a control of the treatment of syphilis. It is unfortunate that no standard technique for the Wassermann test has been adopted. This has been due largely to the difficulty of securing a standard antigen. The author describes most minutely his method of performing the test. This is probably as simple and as accurate as any. The whole subject is most carefully considered in this work from the preparation of the reagents used to the interpretation of the results and it is a book worth while. It is, however, but another contribution to a subject upon which much has been written in the past few years and it is to be hoped that the near future will see some standardization of this work.

HEADACHES AND EYE DISORDERS OF NASAL ORIGIN. By Greenfield Sluder, M. D., Clinical Professor and Director of the Department of Laryngology and Rhinology, Washington University Medical School, St. Louis. 272 pages with 115 illustrations. C. V. Mosby Company, St. Louis. 1918.

Much has been written during the past ten years on this subject. The nasal factors of headaches and eye lesions but the very beginning of this work, taking up the subject from a pathological standpoint, marks it as "something different." The work then proceeds to cover the subject of vacuum frontal headaches with eye symptoms only, the syndrome of nasal ganglien neurosis, hyperplastic sphenoiditis and its clinical relations in the environing nerves and concludes with a chapter on case histories. The work is beautifully illustrated with 115 high grade half tones and drawings and while it is an exhaustive and complete study of a subject the interest of which is usually confined to the specialist working along these lines, it is so written and put together that it will prove of interest and value to any physician called upon to treat this most common complaint—a subject little understood by the general practitioner but of immense importance to him. The section on vacuum frontal headaches will be found to be alone worth the investment.

THE HODGEN WIRE CRADLE EXTENSION SUSPENSION SPLINT. By Frank G. Wifong, M. D., F. A. C. S. 162 pages, illustrated. C. V. Mosby Company, St. Louis. 1918. Price, $3.00.

This is a small work, beautifully illustrated, on the treatment of fractures of the extremities and deals especially with appliances to insure immobility extension and suspension. A revival of interest in the subject has been brought about by the great world war and it is surely to be hoped that a sane application of the laws of physics and mechanics through such little volumes as this may in the future contribute to the comfort and general welfare of our fracture patients and banish some of the appliances described in our older text books which amounted to little more than devices for torture. This book is a worth while contribution to the subject and will prove of special interest to the general practitioner, who lacking facilities ready to use in our larger hospitals, is called upon to devise his own apparatus for the treatment of these cases.

ESSENTIALS OF DIETETICS. A text book for nurses by Maud A. Perry, B. S., Secretary of the American Dietetic Association and Red Cross Dietition for Base Hospital Unit No. 14. 158 pages. C. V. Mosby, St. Louis. 1918.

This is a text book for nurses. It is simple, easily read and will be of value in any training school. It is also intended as a book of reference after graduation. The book is divided into two parts—the first part dealing with the composition of food, its nutritive value and its utilization by the body and the second part with special diet and underlying principles. The work is nicely arranged with a series of "study helps" at the end of each chapter.

CYSTOSCOPY AND URETHROSCOPY. By Dr. Georges Leuys of Paris, France. Translated and edited with additions by A. L. Wolbarst, New York. C. V. Mosby Company, St. Louis. 1915. Price, $7.50.

This work is the result of fifteen years of practical endoscopy. It presents to the medical profession the procedures and methods which have been perfected; and which enables us to determine urethral and bladder mucosa, and also of ureter, pelvis and kidneys. It will be of equal value to students and to those who though quite familiar with the practice of cystoscopy and urethroscopy are not acquainted with all of its useful applications. This work cannot fail to popularize the science of direct vision cystoscopy and the possibilities of its application. The book consists of ten chapters. Urethral and vesical endoscopy are first studied historically and in a general way. This is followed by a chapter on urethroscopy and another on the catheterization of the ejaculatory ducts and the treatment of prostatic hypertrophy. Chapters follow on cystoscopy, prismatic cystoscopy, direct vision cystoscopy, catheterization of the ureters, information derived through uretral catheterization, practical applications of cystoscopy and treatment of foreign bodies in the bladder. This book is truly a work of art. It is a volume of 386 pages printed on a high grade art paper with 217 figures in the text and 24 chromo typographic plates outside the text, including 76 drawings from original water colors. The illustrations are wonderful and will be most helpful to those developing a knowledge of the subject and the need of help in determining the nature of their findings. It is truly the last word on the subject.

THE SURGICAL CLINICS OF CHICAGO. Vol. 2, No. 3. W. B. Saunders Company of Philadelphia.

Beck, Besley, Bevan, Buford, Dyas, Eisendrath, Eisenstaedt, Kolischer, The Ochsners, Percy, Ryerson, Shambough, Smithies, Vaughan & Watkins have contributed to this number. It embraces clinics at Augustans, Presbyterian, Michael Reese, North Chicago, Cook County, Polyclinic, Children's Memorial and St. Luke's Hospitals. It is a collection of 690 pages of clinical teaching which measures up in every way to the previous volumes of this series issued and is illustrated with care seldom found in clinical manuals of this kind. Some of the subjects covered include Renal Calculus and gall stones, kidney and urethral stones, a review of one thousand cases of gall bladder disease, a new method of gastrostomy, injuries of the chest, bunions, flat foot, hernias of infants and children, etc.

THE ORTHOPEDIC TREATMENT OF GUN SHOT INJURIES. By Leo Mayer, A. M., M. D., Instructor in Orthopedic Surgery, New York Post-Graduate Medical School, with an introduction by Colonel E. G. Brackett, M. C. N. A., director of Military Orthopedic Surgery. Illustrated, 250 pages. W. B. Saunders Company, Philadelphia.

Doctor Mayer in this little volume has given the results of a practical experience with many of the problems which have come to us since the war began. Colonel Brackett welcomes this volume as filling a real need at a most opportune time. The complete rehabilitation of the injured soldier is one of the big problems confronting the medical profession today. In every instance no pains must be spared in restoring him back to a normal working life and the needs of surgeons who have a knowledge of this special subject have never been as great. The book is not a treatise on orthopedic surgery but is intended to merely emphasize certain principles and rules of guidance of war injuries. The work covers fractures and injuries to joints, injuries to the nerves, muscles, tendons, cutaneous tissues, transportation of the wounded, bone injuries, joint injuries, contractures, the treatment of nerve injuries, injury to tendons and tendon operations, the treatment of the amputated and concludes with a chapter on the aims and organization of the orthopedic reconstruction hospitals. It is a work filling a distinct need and is sure to find a warm welcome.

SURGICAL TREATMENT. A Practical Treatise on the Therapy of Surgical Diseases for the Use of Practitioners and Students of Surgery. By James Peter Warbasse, M. D., F. A. S. C., New York. In 3 volumes with 2,400 illustrations of which this is Vol. 1. W. B. Saunders. 1918.

The aim of these volumes, as stated by the author, is to make easily accessible the practical application of surgical measures for rendering help in every surgical condition under all circumstances. The author states that the work has been written with the interest of the patient constantly in mind. Operative and non-operative treatments are described together. The work is intended for the surgeon who is familiar with the fundamentals, surgical pathology, diagnosis, prophylaxys, and prognosis are accorded sufficient attention. The first volume covers the general principles of surgical treatment, asepsis and anti-asepsis, surgical materials, their preparation and sterilization, anesthesia and anesthetics, wounds and operations, inflammations (in this is included infected wounds), surgical fevers and infections, fistulas, gangrene, ulcers, nutritive disturbances, tumors, blood and blood vessels, lymphatic system, diseases of bones, fractures, dislocations, diseases of joints, operations on bone and joints, muscles, tendons, skin and its appendages, and nerves. The work is exhaustive and covers the complete field of surgery. It is well printed on a high grade paper and the illustrations are profuse and of good quality, many of them in colors. It is at once a text and reference book on general surgery which will be of value to every practitioner. We predict this will be one of the most successful sets on the subject issued.

Gynecology. By Wm. P. Graves, A. B., M. D., F. A. C. S., Professor of Gynecology at Harvard Medical School. With 368 half tones and pen drawings by the author. 123 microscopic drawings and 100 illustrations in colors. Second edition, thoroughly revised. 885 pages. W. B. Saunders Company, Philadelphia. 1918.

This standard text book has been brought completely up to date. The section on relationship of gynecology to internal secretions has been entirely re-written and amplified. A new section has been added dealing with the relationship of gynecology to the sex impulse according to the Freudian theory. The work is a text book and general reference book which has an established place in American Medical literature. It is divided into three parts, the first of which deals with the physiology of the pelvic organs and with the relationship of gynecology to the general organism, a comparatively new departure. Part two is designated primarily for the under graduate who is taking his initial course and includes a description of these diseases which are essentially gynecologic. Part three is devoted exclusively to the technique of gynecologic surgery and is written for the assistance of the advanced student and practitioner. The illustrations prove the author an artist of no mean ability as well as a recognized authority on the subject. This is a work which will continue as one of the standard text books on the subject and it is most deserving of the place in medical literature in which it stands.

Remember that the soldier's chance of life depends upon the support given him by the folks back home. Help! Save and buy War Savings Stamps.

Uterine Inertia. Paul Titus, Pittsburgh (*Journal A. M. A.*, Sept. 14, 1918), takes up the subject of uterine inertia with an analysis of a series of cases observed. It is not known, he says, why labor occurs at about the end of 280 days, but if the stimulus to its induction is normal and the uterine muscle tone is good labor will go on actively and progressively. The propriety of classing uterine inertia as primary or secondary is extremely doubtful. Unless there is some abnormality it is always primary. It may be due to constitutional debility from disease or to early rupture of the membranes and dry labor. We should make a distinction between inertia and exhaustion, the latter being what is ordinarily understood as secondary inertia. In the author's series of cases there were no maternal deaths, but five infants were born dead or could not be resuscitated from their asphyxia. He calls attention to the danger of using pituitary solution in any stage of labor. It is safest after the expulsion of the placenta, and in this respect is like ergot. He concludes that the differentiation between inertia and exhaustion is important from a standpoint of treatment, that of the former being more or less expectant, while that of the latter should be prophylactic and directed to the obstacles of delivery. True inertia begins in the first stage, and if the membranes are unruptured the use of mild uterine stimulants may be alternated with rest from the use of narcotics until the second stage is reached, when active interference may be necessary. If the membranes are ruptured interferences may be required, according to the condition of the mother. This includes Duhrsseon's multiple incisions of the cervix and vaginal cesarean section, both followed by forceps delivery or the use of cervical bags. In the second stage interference is not so serious and is usually by forceps delivery. Frequent vaginal examinations are to be avoided and should be substituted by rectal examinations. Premature rupture is a common cause of inertia in a healthy woman, while constitutional defects, overdistention of the uterus by twins, hydramnois, and frequent pregnancies the also important etiologic factors. Placental retention, with or without hour glass contraction of the uterus, is a common result of the inertia extending into the third stage, and hemorrhage is likely to occur during and after the placental stage.

If the man of wealth thinks that War Savings Stamps and their meaning are not for him he is mistaken. It is true he can buy only $1,000 of them, but he is more able than most folks to accept the philosophy of the stamps. That philosophy is, Save! Save! Save! Julius Rosenwald says: "That man financially able to indulge himself in luxuries during war time has the least excuse for doing so."

Secretary Baker says 800,000 of our boys have gone to the front. Help bring them back quickly by saving to the utmost of your ability and buying War Savings Stamps.

The Wisconsin Medical Journal

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ORIGINAL ARTICLES

CARDIAC DISTURBANCES FROM THE STANDPOINT OF MILITARY SERVICE.*

By J. S. EVANS, M. D.,

MADISON.

Our own experience during the civil war as well as that of our Allies during the present war, in that many men have broken down under the strain of active field duty as the result of cardiovascular disturbances has shown us the importance of recognizing the frequency of so-called functional disturbances of the heart which may have a basal organic etiology. Such disturbances under the limited stress of ordinary life usually produce symptoms which are mainly subjective and which generally have been belittled by the profession because of the tendency to base diagnoses of organic heart disease upon signs secondary to anatomic changes in the valve leaflets and in the size and shape of the heart, and upon those objective and subjective symptoms which result secondary to loss of compensation. The strain of warfare, however, shows very clearly that there is a certain type of heart which has not been considered by the average civilian practitioner as cause for limitation of nervous and physical activity, which needs careful study not only from the standpoint of protecting men so afflicted from the damage of war campaigning, but from the standpoint of determining the etiology of such disturbed functional manifestations in order to prevent their occurrence and to correct them whenever possible.

From the voluminous reports[1] upon this subject which have appeared in the French and English literature it is the consensus of opinion that a valvular defect as evidenced by the presence of a murmur per se, is not necessarily a cause for rejection since both aortic and mitral lesions have been discovered in men who are in active campaigning without being accompanied by symptoms of distress or by signs of failing compensation. Valvular defects, however, associated with permanent changes in the size and shape of the heart, indicating previous dilatation with secondary compensatory hypertrophy, associated with disturbances of normal rhythm and vascular hypertension preclude any activity involving overstrain. In other words, those hearts giving evidence of a disturbance in the blood stream, as shown by the production of murmurs, and of a defect in the myocardium or the intrinsic or extrinsic nerve mechanism of the heart were found to give way to the strain of army service.

Evidences of arteriosclerosis, hypertension, arrhythmia and changes in the size and shape of the heart without accompanying murmurs have been found to be the underlying factors in men who have succumbed to circulatory distress. In addition to these disturbances, the subjective and objective symptoms of which are sufficient to classify the cases under a distinct clinical entity, there occurs with great frequency a syndrome which has been described as the "soldier's heart", as the "irritable heart of the soldier" and as "the effort syndrome". The pathogenesis of this condition is still undetermined and there is a great confusion of ideas presented by the various observers as to the primary etiology. There is, however, a tendency to agree upon one point, namely, that the syndrome is due to insufficiency of the myocardium. The symptomatology of the syndrome is practically uniform as reported by the various observers. Upon exertion there is dyspnoea, precordial pain, palpitation, vertigo, profuse sweating, vaso-motor irritability and tachycardia. The increase in rate of the heart action upon exertion above the average normal limit and the failure of the heart to resume its normal rate within a given time when the patient is placed in the recumbent position is the predominant sign in the diagnosis of this condition. The physical examination aside from the pulse rate gives little information of specific value in the determination of this condition which seems to indicate a lack of capacity on the part of the heart.

*Read at the 72d Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, October 3d, 1918.

Therefore the determination of cardiac fitness depends upon the estimation of cardiac capacity. This necessitates an accurate knowledge of the individual and of the character of the strain under which he may be placed. Too often in daily practice the strength of the heart is decided upon from the subjective and objective symptoms present either when the individual is at rest or carrying on physical activities within his limitations. In the absence of cardiac distress or signs of loss of compensation it is concluded that the heart has fully compensated for the burden of an organic lesion or that an irregularity is purely neurotic.

It is obvious that to place an individual under severe physical strain in order to determine the limits of cardiac capacity is unwarranted because of the possibility of permanent serious damage. Therefore it has been the endeavor of cardiovascular specialists to devise certain quick and easy methods of determining myocardial response to effort. The opportunity of observing a great number of men with disordered action of the heart has led the military medical officers to conclude that the best simple test for cardiac capacity is the pulse rate response to exercise and to rest.

First allow me to call your attention to the possible mechanical effect of abnormally slow or abnormally rapid heart action. If the normal rate of the heart is 75 beats per minute an increase or a decrease of 25 beats per minute may be considered as being within normal limits. That is, a rate of 50 or 100 apparently does not interfere with the ventricular efficiency. When, however, these limits are exceeded it is found that the prolonged diastolic filling of the ventricle in rates below 50 leads to primary dilatation while the extra systolic effort to completely empty the over-filled ventricle produces secondary compensatory hypertrophy. This is evidenced clinically by definite left ventricular hypertrophy unaccompanied by valvular, renal or vascular defects and is noted in the anatomic changes accompanying the slow heart of heart block. When the heart rate with the body at rest exceeds 100 for any length of time we find secondary changes in the heart due to the incomplete ventricular emptying. Take for exemple a rate of 140 or over. Here the ventricle is contracting twice the normal rate in order to maintain a normal blood flow. The ventricle is pumping considerably less blood because of insufficient filling and reduced contraction. Both of these deficiencies in cardiac function are due to the shortened period of rest which permits neither the usual degree of filling at the beginning of contraction nor the accumulation of the energy yielding material in the heart muscle which would give rise to a contraction of normal strength and extent. This gives rise to increased venous pressure and ultimately leads to the dilated and rapid beating heart. As the nutrition of the heart depends upon the pumping efficiency of the heart, and vice versa, there arises a vicious circle leading to increased cardiac incapacity. If this continues for a long period or at frequent intervals the muscle of the heart must undergo a functional strain leading to permanent organic changes. If the excessive rate is associated with arrhythmia or with a valve defect it is obvious that an added serious strain to the myocardium occurs. In "paroxysmal tachycardia" we are able to note anatomic changes, the result of this type of ventricular inefficiency.

Aubertin[2] suggests a heart test as follows:

Notation of:

1. The dyspnoea produced by a given exercise—*effort dyspnoea.*

2. The intensity and acceleration of the heart produced by the same exercise—*effort tachycardia.*

3. The acceleration of the heart on assuming the upright position—*orthostatic tachycardia.*

The test as applied has varied somewhat with different observers but has been uniform in a given series of cases. For a number of years past we have employed such an effort test at the Uuniversity of Wisconsin in the examination of men applying for permit to train for intercollegiate contests and as the test does not differ materially from that employed in France or from that recommended by the Office of the Surgeon General it may be described in detail as a method which has been proved to be of value:

1. The heart sounds and the pulse rate are noted in the erect and recumbent postures.

2. The changes in heart rate between the recumbent and standing postures and the time of return to normal after assuming the recumbent posture is noted.

3. The patient is directed to take 50 running stationery steps with knees well drawn up within

a minute (the Surgeon General's Office recommends 70 hops on one foot). After this the pulse rate and the sounds are noted for a period of two minutes. The production of murmurs, irregularity and the return to the normal rate are observed.

4. If the pulse rate returns to the normal rapidly, the running steps are again taken and the patient placed in the recumbent posture and the time for a return to the normal rate determined.

A normal heart should increase in rate about 8 to 10 beats upon assuming the erect posture after rest. The normal rate should return within a minute upon again assuming the recumbent posture. In irritable hearts the return to the normal is prolonged and the initial rise in rate is greater. After exercise the pulse in normal individuals shows an increase of 20 to 25 beats, while in irritable hearts the increase is always above 100. In the normal hearts the return to normal occurs within two minutes, while in the irritable heart the return to normal is delayed. In the hearts of diminished capacity murmurs are apt to occur indicating that the inefficiency of the ventricle often interferes with the sufficiency of the auriculo-ventricular leaflets. In some instances changes in the size of the heart have been noted indicating an over filling and stretching of the ventricle. From these experience with athletes we concluded that irritable action of the heart warranted refusal for permit to enter sports requiring sudden physical strain. If such irritability occurred during training for a sport we believed it was an indication that physical activities should be curtailed. The experiences during the present war suggest that our conclusions as to the importance of the failure of proper response to physical strain in the diagnosis of cardiac defects were warranted.

The etiology of the irritable heart is open to several explanations but I believe that it is proper to state that it depends ultimately upon the strength of the myocardium no matter what the primary contributing cause may be. In this regard our own observations coincide with the reports from the examination of a great many men with "soldier's heart" at the front in that the following are apparently factors in the production either of myocardial degeneration, inflammation and irritability or of some disturbance of the extrinsic nervous mechanism of the heart:

Infection,
Toxemia,
Hyperthyroidism,
Hypersusceptibility of the general nervous system,
Mechanical irritation,
Overstrain.

Infection and toxemia: According to the studies of Lewis[1], Mackenzie[1], Allbutt[1], the majority of individuals with "soldier's heart" had had some form of infection and the symptoms noted were analogous to those appearing in the convalescence from acute infectious diseases or in the early stages of pulmonary tuberculosis. Lewis attributed such instability of the heart to "true toxic bodies acting on the heart itself or to disorders of cellular metabolism resulting from infectious processes." To those of us who feel convinced that myocardial degeneration or true myocarditis is most frequently due to an actual infection of the heart muscle produced by bacterial emboli in the terminal capillaries with secondary changes, resulting from the disturbed nutrition, in the form of either proliferative fibrosis or fatty degeneration, it is immaterial whether or not the term infection or toxemia is used since the primary etiology is dependent upon the invasion of bacteria into the body which have an effect upon the heart muscle. In our observations upon young adults we have noted that irritability of the heart is frequently found in those individuals giving a history of repeated attacks of tonsillitis, of rheumatic fever, of the acute exanthemata and of diphtheria. It has convinced us of the frequency of a permanent and often unobserved laming of the myocardium in acute infectious diseases even when the endocardium has escaped. Brisco's[3] observations that the irritable heart is associated with a leucocytosis suggests the toxic or infectious origin of the condition.

Hyperthyroidism is of course a recognized factor in producing tachycardia. Such individuals are prone to cardiac fatigue and poor reaction to effort. Bardeen[4] has observed in the radiographic study of such individuals that the heart is of peculiar shape, giving somewhat the appearance of a paper bag full of water as if the organ had an absence of tone in diastole.

Hypersusceptibility of the general nervous system is a factor that has been noted but the

mechanism of its relation is not fully explained. We cannot deny, however, that certain individuals seem to have an inherently non-resistant nervous system which leads to all sorts of functional disturbances. The "irritable" heart associated with hypersusceptibility of the general nervous system must be differentiated from the temporary rapid pulse associated with psychic excitement. In the latter case the rapidity usually disappears when the patient is placed in the recumbent posture, the response to exercise and rest maintains a normal relation and exercise is apt to reduec the rate to the normal.

Mechanical Irritation: I speak of this because of our observations in cases of "paroxysmal tachycardia". In the radiographic study of such cases we have noted the evidence of mediastinal fibrosis and adenitis and believe that this condition may in some way be connected with the sudden attacks of rapid heart action followed by just as sudden a subsidence to the normal rate. It is interesting to note that recently Wybauw[5] observed the relation of irritable hearts and mediastinal adenitis.

Overstrain is looked upon only as a possible cause of myocardial irritability by those who have been studying disordered heart action in soldiers. In our own observations we have emphasized the probable importance of the changes in size and shape of the heart due to dilatation and secondary hypertrophy apparently the result of sudden overactivity. We have felt that such hearts required an increased amount of energy to accomplish the same amount of work as a normal heart because of the inability of a dilated heart to completely contract. While such hearts do not usually show evidences of myocardial irritability during a period of continued muscle activity, after the individual gives up regular exercise for a prolonged period and then resumes those activities requiring sudden strain the cardiac capacity is below normal.

It is therefore obvious that the syndrome described is merely a symptom complex of a lack of cardiac capacity due to a variety of morbid conditions. As such, it is difficult to accurately diagnose. It is apparent that to depend upon a single test will lead to incorrect conclusions in many instances since we are not able to determine all the factors involved. Therefore, while I wish to impress you with the importance of making simple tests for the functional response of the heart, I also desire to point out to you the inadvisability of depending solely upon such tests for your conclusions.

In cardiac diagnosis the most careful clinical methods should be employed. The history of past infectious diseases and the presence of persistent foci of infection should be determined. A heart murmur is only of importance when changes in the size and shape of the heart are determined. Extrasystoles after 40 are of pathological significance because they are usually associated with fibroid myocarditis; before 40 the cause of irregularity must be determined. Complete arrhythmia is always significant of an organic lesion. Respiratory arrhythmia is of no signifieance. Hypertension and evidence of sclerosis are of importance. Tachycardia must be given special study. No matter what the original cause may be if the heart exhibits an abnormal reaction to exercise and a failure to resume its normal rate suddenly it is prima facie evidence that it is unable to accustom itself to strain. The probable etiology should then be sought and if possible the cause should be removed since the removal of infections has frequently been followed by the establishment of normal rhythm and apparent normal heart capacity. Therefore in cardiac diagnosis we should pay especial attention to the determination of infectious and toxic factors which may have an effect upon the muscle or the nervous mechanism of the heart.

To sum up: In determining whether or not a given individual is to be qualified for military service from the standpoint of cardiac fitness we should

1. Determine the integrity of the valvular mechanism, this determination depending chiefly upon auscultation.

2. Determine the relative size of the heart. Percussion will give fair evidence of enlargement. X-ray methods are more accurate.

3. Determine the quality of the peripheral blood vessels. Palpation and observation in a good light are necessary.

4. Determine the functional capacity of the circulatory system. The pulse rate lying and standing, before and after exercise, gives fairly accurate evidence. This test may be confirmed by arterial and venous blood pressure estimations.

5. Determine, when there is functional disturb-

ance, whether or not there are transitory factors present, such as acute infections, drugs, etc.

The final determination should be made by giving due weight to the various factors above mentioned, the greatest weight being given to functional disturbances associated with signs of anatomical defects.

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DISCUSSION.

Dr. H. P. Greeley, Madison, Wis.: Mr. Chairman and Gentlemen. Those of us who heard the discussion of this subject at the American Medical Association meetings in Chicago, will, I think, appreciate this paper, because to me it is very much more practical and valuable than the discussion there. I hope that the paper Dr. Evans has presented will be published as soon as possible in the Journal, so that it will be of help to the legal and medical advisory boards, because I think it is just exactly what we have all been looking for.

Major L. M. Warfield, M. C., Jefferson Barracks, Mo.: The subject of cardiac disturbances from the standpoint of military service is one which assumes more importance the longer one remains in the service and the more men one examines.

From a rather varied service during the past few months the following points have impressed me:

First: Some diastolic murmurs are missed. These are often true cases of aortic insufficiency in which there is added the further element of cardiac hypertrophy. These cases are unconditionally rejected. I have found a certain number in young men in whom no history of any infectious disease could be elicited. These were evidently due to endocarditis, but an endocarditis which was symptomless, the very mildest form which we do not see in process of evolution. Other diastolic murmurs are the presystolic murmurs of true mitral stenosis. These are often even more difficult to detect. In them the heart is usually not enlarged to the left. These can and must be distinguished from the cases of palpable presystolic thrill without audible murmur so often found at the apex in apparently normal hearts. Such cases unfortunately have evidently been diagnosed mitral stenosis and men have been discharged who have had normal hearts. Mitral stenosis also occurs without history of infectious disease, as I have recently called attention to in J. A. M. A., Sept. 21st, p. 970.

Second: Scrutinize all *systolic* murmurs carefully. The large majority even heard at the apex are of no significance. They assume importance when the heart is enlarged, the exercise response is poor, or when the subject has had one or more attacks of rheumatic fever. No attention should be paid to simple systolic murmurs heard at the base. Aortic stenosis is a rare disease and it is doubtful if it ever occurs as a single isolated lesion.

My practice in regard to systolic apical murmurs (I was the cardio-vascular member of the board for referred cases during the examination of over 60,000 men) is to accept all cases with normal sized hearts which respond normally to the hopping exercise, and to reject all cases with enlarged hearts even though they respond normally to exercise. Further I have rejected men with normal sized hearts and normal exercise response if they have had more than one attack of acute rheumatic fever. Much judgment is essential in these cases. Suppose a man had an apparent mitral insufficiency with rheumatic history of more than one attack, but who has had diseased tonsils removed, has had no symptoms for months, his heart is normal in size and exercise response is normal. Shall he be rejected? Shall he be placed in the Limited Service group? This is a point sometimes difficult to decide. As a rule I have accepted such a man, particularly if he has been an athlete or a laborer and has no history of symptoms.

Third: The most difficult cases are the ones showing tachycardis without heart lesions. We have been studying such cases at Jefferson Barracks and find in brief the following: Tachycardis usually has some pathological basis. (I am, of course, excepting the slightly increased pulse rate of excitement.) Our experience is that pulmonary tuberculosis, myocardial degeneration, hyperthyroidism and exophthalmic goiter, liver cirrhosis, chronic malaria, chronic bronchial asthma, chronic focal infections, have been the cause in most cases. A careful examination or examinations are necessary to make the diagnosis in many cases. In other cases inspection alone will tell the diagnosis. There is beyond these conditions, however, a group of cases variously called irritable heart, effort syndrome, neuro-circulatory asthenia, in which no apparent cause can be found. These cases are characterized by response to the simple hopping exercise out of all proportion to the exercise. There is breathlessness, exhaustion, pain over the heart, dizziness and palpitation. The history of these cases is most important. Such men have never been able to do any violent exercise. Often they give a history of fainting for no apparent reason. Their occupations are light or sedentary, and frequently they will say that they changed from heavy or moderately heavy to light work because they found that they could not do any light work. We have had many farmers and mechanics in this group. They flush easily, become easily excited and are nervous. While examining these men the hands are blue and cold while the sweat runs in streams from the axillae. Watch for this condition. It is much more frequent than any of us ever believed. They are the bane of the cardio-vascular boards. They are in service for a week or a

month or more and eventually must be discharged. If these men could be picked out by the Local Examiners and Advisory Boards before they are sent to camps, it would save thousands of dollars to the government.

We believe that this can be done in the great majority of cases. Hesitate to brand a big fellow a slacker or a malingerer until you have all your data from history and examination. And obtain a history, a careful history. Then with that as a guide and the development of the symptoms under exercise, there should be many of these men rejected or held for strictly Limited Service when they are expert clerks or expert in other work requiring no physical exertion worthy of the name. But they are *not fit for general military service* in spite of the often apparent robust appearance. These cases are difficult to pass upon. It is our practice at the Recruit Depot to place all suspects in the hospital for observation and exercise. In this way we have been able to determine very definitely whether these men are fit for any position in the army.

Much more could be said of this interesting group of cases, but enough has been said, I hope, to enable you to detect these cases and to place them in their proper class.

Dr. Evans, Madison: Mr. President and Gentlemen. Dr. Lyman has just called my attention to the fact that in his medical advisory work there have been a number of cases in which the heart rate has slowed down with exercise. That is usually a good sign. It makes no difference what your initial heart rate is, your test should be based upon that initial heart rate. If you have an individual who is very much frightened by the examination, and comes to you with a heart rate of over 100, it is probably due to psychic excitement or to the lack of vagal control. You will find upon exercising your patient that there will be an immediate drop to the normal heart rate. That slowing down of the heart under exercise is a good sign, providing there is no accompanying disturbance in the rhythm of the heart.

IN THE SAME BOAT.

In one of the big base hospitals of the army not long ago a new librarian was set to work by the American Library Association. She was a very charming young woman, and very anxious to please all of her "customers," though some of them didn't even wish to look at a book. In her rounds she approached one of the patients and he declined to be interested in her wares. At the next cot she stopped and offered its occupant a book.

"What's it about?" the patient asked.

"Oh, this is Bambi," said the librarian. "It's about a girl who married a man without his having anything to say about it."

"Hold on there," shouted the man who had declined all books. He raised himself up on his elbow and reached out his hand. "Give me that book. It's my autobiography."

HEALTH INSURANCE.*

By PROF. J. R. COMMONS,
UNIVERSITY OF WISCONSIN,
MADISON.

Mr. Chairman and Gentlemen: Some years ago when the subject of workmen's compensation was being discussed in this state, the objections raised to that measure were quite similar to those now raised against health insurance. I remember speaking, some 9 or 10 years ago, at various associations in Milwaukee and other places, and always met these three objections: the enormous expense of workmen's compensation, the paternalism of workmen's compensation, and that it was beginning at the wrong end, beginning with compensation whereas it ought to begin with accident prevention. I think those three arguments sum up or condense the objections now raised to compulsory universal health insurance.

Quite along the same line as the objections to compulsory workmen's compensation or accident insurance, possibly a little stronger now than it was at that time, is the objection which goes under the name of paternalism. At the present time we have much stronger arguments against paternalism than we had ten years ago, namely, that this health insurance proposition originated in Germany; that it represents a despotic and paternalistic form of government; that it is unsuited to our democratic institutions; and consequently, the proper way of meeting or attacking the proposed compulsory health insurance is to say that it is hatched in Germany, that Germany is trying to spread it through the rest of the world in order to render the other nations as undemocratic as Germany is.

It is true that health insurance originated in Germany. And so did accident compensation. Germany had accident compensation 25 years before we had it. Germany had compulsory health insurance many years before any other nation had it. England and France and other countries did not adopt these measures until 20 years ago; Germany had them 35 years ago. But do we hear anybody proposing to abandon workmen's compulsory accident compensation because it was

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fathered in Germany? Germany has borrowed more things from America and England than England and America have borrowed from Germany. Germany has taken a lot of our good things and "played the devil with them". There is no particular reason why we should not take some of Germany's things that work well and democratize them. And that is what we did with accident compensation. We found accident compensation met a decided need of modern industry; and when the thing was started in this country and the courts finally conceded that it was constitutional, then every industrial state rapidly followed the lead and adopted workmen's compulsory accident compensation.

Consider some of the features of that accident compensation law and its differences from the proposed health insurance, for I contend that the health insurance is the next step additional to accident compensation; that it will require no more machinery than the accident compensation law; that it will be operated under the existing machinery which now operates the accident compensation law, and that it is inevitable that it must follow sooner or later, from the steps already taken.

Is the accident compensation law a paternalistic piece of legislation? How much has it increased the activity of the state or the field for politicians in the state? I contend that the greatest force in eliminating politics from the Labor Department in the State of Wisconsin has been the accident compensation law. Prior to the adoption of that law, 8 or 9 years ago, our Labor Department in this state was manned by politicians, appointed for political purposes, and conducting political activities, when they were supposed to be inspecting factories; but since the accident compensation law the State Industrial Commission has been as fine a body of experts in safety, in accident prevention, in co-operation with the medical and industrial bodies of the country, private or public, as you can find in any association of professional men. The accident compensation law has eliminated politics.

Furthermore, it has reduced the activity of the state, as a matter of fact, for the state does not pay the compensation; the state has not increased its force of people to carry on this accident compensation law. I do not think there are more than ten people employed by the state as a result of the accident compensation law. There are a few clerks and statisticians that have been added. The state has set up a judicial machinery in the form of the Industrial Commission which holds hearings and decides disputes, makes rules and regulations; but it imposes upon the employers of the state a duty.

It imposes upon the employers of the state a duty of compensating every accident that happens in their establishments, no matter who is at fault, no matter whether it was the fault of the employer, whether it was the fault of the working man, or whether it was the fault of a fellow servant, or whether it was an act of God; they compensate for all of them. Under the old law he compensated about 5 per cent of all the accidents; now he compensates 100 per cent. And more than that, he must provide medical and surgical aid for all of these cases, must cure them as rapidly as possible, and as efficiently as possible. The medical and surgical aid cost about 25% of the total expense. All the other expense, the compensation for the working man who gets 2/3 of his wages while incapacitated, and all the other expenses the employer meets, is about 75%. And lastly, compulsory insurance. He must insure himself in a safe insurance company, in a mutual company, or, if he is a large employer he can carry his own insurance. In other words, all that the state does is to establish certain standards, 2/3 of the wages, adequate medical and surgical attendance, and adequate reserves in the insurance company with which he associates, to indemnify the worker and to meet these medical and surgical bills.

Then the state sets up this Commission, to see that the employer does these things, to see that these standards are carried out, to see that insurance is properly taken care of. So that there are just three things that are provided, and those are made obligations upon the employer. He can organize in any way that he pleases. He does it himself, not the state.

What has been the result? It has substantially reduced the amount of Government activity, because it has been taken out of the hands of the courts, which formerly were occupied very much of their time in listening to these suits for damages and in cases of accident and negligence cases. Those cases do not come up any more. That activity of the state has been diminished. On the other hand, another activity of the state has been

increased—this which I have mentioned. I should say on the whole that the state government is spending a decidedly less amount of money for accident compensation than it was under the old law, or lack of legislation. Under the old law it had to support the courts. That was paternalism. That was coercive paternalism. Under the present system it has to support this machinery for accident compensation. That is paternalism, but it is co-operative paternalism.

Under the old system the employer is treated as a criminal; if he is negligent, he is prosecuted; if he violates the law of safe-guarding his property, then the state sends out its factory inspectors, these politicians I have been speaking of; they hunt up the evidence; they bring suit against the employer; he is treated as a criminal, his act is made a misdemeanor, and he is prosecuted and treated as a criminal.

Under the new legislation it is made the financial inducement of the employer to reduce the number of accidents. Employers nowadays who are progressive can make more money in reducing accidents than they can in any other part of their business. By reducing the amount of accident compensation and medical expense, they can make more money. The United States Steel corporation published figures which show that for every dollar spent on accident prevention work they are saving some $10 on outgo in the matter of expense for compensation and attendance.

What the law has done by making accident compensation universal and compulsory has been to create a new profession. It has created the profession of safety expert, of welfare manager, a profession which now has its annual convention of men who are as devoted and enthusiastic as missionaries, for they feel that they are doing one of the great pieces of work in this country—saving the lives of fellow men. And why is it? It is because they can show the corporations, and they can show their employers that it is good business; that it makes money for them. And so you find a new profesion, the finest body of men you find in any profession, large numbers of them throughout this country, holding their annual conventions with a great new mission—a mission which not only makes money for their employers, but saves lives and limbs for the working people.

So that this workmen's compensation law, while it starts with compensation, while it starts at the wrong end, while it starts at compensation rather than prevention, it starts from that end because that is the psychological end to start at. It begins from the compensation end, because there is where the employer's pocket-book lies; there is where his psychology radiates. You start with compensation, and that makes it profitable for the employer to adopt prevention.

It is much the same way with health insurance. Health insurance proposes simply to take the next step. There are a few additional features. First, that all employers shall insure their working people, not only for accidents but for sickness, all kinds of sickness, no matter what kind it is, or whether the employer was responsible, or whether the workman was responsible. And it also has those three other features, compensation to the worker for loss of time while sick, medical treatment, hospital treatment, while sick, and compulsory insurance. The employer must insure himself so as to be financially safe in making these two payments.

Possibly there may be some differences which should be introduced in the treating of health insurance as compared with accident insurance. For my part, I think that there should be no cash compensation paid. I think the compensation should be dropped entirely from the health insurance. Compensation means that the workingman is paid 2/3 of his wages during the time that he is disabled. In the case of accidents he begins to get his compensation after the 7th day, 2/3 of his wages. It is proposed by a good many people that he should get 2/3 of his wages out of this insurance fund while he is sick. My idea is that that is too much of a temptation to malingering. I would cut that out, or at least I would reduce the compensation which the workman has,—the so-called compensation while sick—to a minimum, and would postpone it for several weeks until after the time of the accident.

There is only one reason that I can see why a workingman should be compensated while he is sick, and that is the certain psychological effect it has on him, that he feels willing to take the treatment, and not return to work too quick in order to earn money. There is certain strength in that argument. But I would leave that out of the compulsory feature. I would say that if a workingman wants to have compensation while he is sick, let him join a voluntary insurance society; let him

join his trade union, or some other association, and then I would concentrate this whole proposition of health insurance on the medical end, the expense that is to be paid out of this insurance fund to be for the curing of the sickness; and I would make the medical provisions so extensive, covering every defect of the workingman, all matters of health, all matters of physical defect, all matters of weakness, that the provision for medical treatment and hospital treatment should be the main thing. Make that comprehensive and complete. Then we should expect that the employers of the community would acquire as much interest in a movement for "health first" as they now have in the movement for "safety first". It would be financially to their advantage to see to it that every workingman is in first class health, every workingman in their employ, because that will reduce the premiums paid into the insurance fund. We should then have in the movement for better sanitation as great a financial interest as we now have in the movement for accident prevention.

Look what the employers are doing to inspire the idea of "safety first" amongst their workingmen. The workingman is careless, much more so than the employer, always has been so, of accidends, and of his health. He needs education. But who is going to educate the workingman? Can the public health authorities educate him to take care of himself—safety first? Can the physician educate him? No, the persons that can educate him are the people who are on the job every day, that is, his foreman, his safety expert, his employer. And so you find in the more progressive establishments that the employers have built up their safety committees; the workingmen are on those committees; there are all kinds of posters and bulletins, all kinds of motion pictures, and every boosting proposition that the employer can handle is put before the workingman.

More important than that, the workingman who does not take care of himself is disciplined, laid off, discharged, as a menace to the other men, and a menace to his employer. So the greatest educational agency in "safety first" has been a profit to the employer. He has gone out to educate his workingmen, as well as putting in safety devices in his establishment. Likewise we enlist the financial inducement of the employer to promote "health first" amongst his workingmen, and get them to take care of their health, in order that they may reduce the premiums which the employer would otherwise be compelled to pay into this insurance fund.

There is still another feature. Not all sickness originates in the factory or in the shop; much of it comes from the home, much from the municipality. It would be unfair that the employer should be required to bear the whole burden of sickness insurance. He is compelled to bear the burden of accident compensation, although he is not responsible for two-thirds of the accidents. The industry is responsible for them as a whole, or the workingmen themselves are responsible for them. The employer is not individually responsible for more than one-third of the accidents now happening in industry. But in the case of health, there are such large outside factors that undoubtedly the workingman should also be required to contribute to the funds. He should be required, perhaps, to contribute in equal amounts with his employer to the sickness fund. And if he does so, then the sickness fund can take in his family, wife and children. It will be made mandatory upon him. The bills will be collected out of his payroll. The employer will simply check it off at the end of each pay day and will pay all of the amounts, both his own contribution, and that of the workingman, into the insurance fund.

I shall not go into the question of estimate of costs. It probably will cost considerable. The real question is whether it is worth while or not, whether the health of the working people and all of these other financial inducements to improve the health of the people are worth while or not. I think it can be shown that, no matter what it costs, the returns will be as profitable as they have been in accident compensation. Every dollar spent in this respect will bring $10 return to the people, to the nation, in the improved health, in improved physique, in improved output and productive energy of the working people, in national stability and strength, and in the future vigor of our nation. I think it will be the most profitable investment that we could possibly make.

And furthermore, it will not be an increasing expense. We will spend great amounts of money for hospitals; great amounts of money for equipment, in the prevention of sickness; enormous amounts of money will go into those directions not hitherto developed, because every dollar put

into these preventive agencies will be a profitable investment for every corporation. It will be just so much deducted from the benefits which they must pay on account of sickness, and as the sickness rate reduces, the hospital and other equipment will increase.

The other element concerned with this health insurance proposition, the employer paying one-half, and the employee paying one-half, the state not paying anything except for the expenses of supervision, is the medical profession. Unquestionably health insurance involves a closer and more authoritative organization of the medical profession. We will have then the three elements, the three factors operating this system: the state will act solely as the supervising agency to see that the thing is done correctly—but the three elements that operate the system will be the employers, through their organizations, the workingmen through their representatives, and the medical profession through its chosen representatives. They will constitute the boards, the advisory and the controlling boards. They will control the compensation for the physician; they will control the funds and control the hospitals jointly.

There will be boards in which the physician will hold the balance of power. He operates as mediator and arbitrator between capital and labor; he is the expert that tells whether the man is sick of not, whether entitled to aid, and he is the one upon whom both the employer and employed will rest for the successful operation of the system.

The state will see to it that the accounts are properly audited and cared for, and that the bills are paid, because it will be compulsory; but the actual operation will not be conducted by the state at all; it will be conducted by these various associations through, partly, a state organization, through their local and city organizations, and through the shop and trade organization. We shall have not a paternalistic system which the state or the politicians operate, but we shall have a system composed of representative democracy, in which the organized interests, those who do the work and those who pay the bills, will be the managers of the system.

I will not stop to go into further details. I simply want to put forward the general proposition that this is not a proposal to increase jobs for politicians; it is not a proposal to increase the authority or power of the state; it is a proposal for lessening the amount of political activity, and bringing forward the private activity of the individual, of the association, of those most directly concerned with the issues at stake.

There is one other thing that is forcing this class of legislation upon the state and upon the people. Already health insurance is upon us. If you will consult the literature which is circulated in opposition to this health movement, you will find that it all originates from one source; all of the ammunition, all of the facts and statistics that you may come across, no matter who gives them to you, will be found to go back to the Prudential Insurance Co. of America, and to Mr. Frederick L. Hoffman, their very eminent statistician; whether these figures come to you directly through what he calls his "Facts and Fallacies", or whether they come through other people, like the National Civic Association, you will find Mr. Frederick L. Hoffman has furnished all that ammunition. Now what is the interest of the Prudential Life Insurance Co. in this matter? The Prudential Life Ins. Co. is one of the great industrial insurance companies of the Country. These industrial insurance companies have some twenty or thirty million workingmen taking out industrial insurance. What is industrial insurance? The workingman pays 5 or 10c a week for his insurance, and what he gets is about $100 or $150 for funeral benefit. Industrial insurance is funeral insurance. The most urgent need of the workingman, the one first thing that he insures himself against, whether it be with his trade union, or in any form of insurance, is not to insure his family, not to insure his children, but to insure himself and them a decent burial. Funerals are what he is insuring himself against. These insurance companies see that if this health insurance is spread, their business as insurers of funeral benefits will be cut in two.

Also these insurance companies have developed a most ingenious substitute for health insurance. Their enterprise is certainly to be commended, and they have set a model and an example. They have practically worked this thing out for us under what they call "group insurance". Group insurance I consider is the highest gift that the insurance business has yet bequeathed. These companies are writing, in the last 3 or 4 years, what they call group insurance. Group insurance is a very ingenious and simple thing. The insurance

company will write insurance for a great corporation that has say 30,000 employees; it will not ask any physical examination. It will simply ask, what do you want to pay your working men? Well, the employer will say, I want to pay them $1,000 death benefit. I want to pay an old age pension after they are 65, I want to pay them a permanent disability, I want to pay them sickness compensation, I don't care about the accident, because that is already cared for by the law. Well, he will take up these four features, death benefit, old age pension, permanent disability, sickness. So the company will figure out a percentage upon its pay roll, at which it will write that group insurance, and every man in the employment of that firm will be insured, no matter what his health is. It is a blanket group insurance, and it costs, as they write it now, leaving out the health insurance, about 1½% on the pay roll, figuring out about $10 or $12 a year possibly for each employee.

The spread of group insurance has opened up a great new field of business for these insurance companies, and I think it is one of the finest things the insurance companies have done. Health insurance proposes to make compulsory what the insurance companies are now doing voluntarily. It proposes to make compulsory and universal group insurance. The actuarial problems are already worked out by these insurance companies.

But under the system as it goes now, not more than 5 or 10% of the employers can be induced, perhaps, to take out this group insurance. Some large corporations, more intelligent than others, will take out group insurance; others who having practiced with it a while will figure that they can carry their own insurance, which they do, and then they call it a welfare scheme; but whether it be called a welfare scheme, or whether it be called group insurance, it is the same thing; it is the employer insuring his employees for sickness, old age and death.

And the more enterprising and progressive and well-to-do, well-informed employers are taking it up. Compulsory health insurance proposes to make that mandatory upon all employers.

The trade unions have not yet all of them been won over to this scheme. The insurance companies want the proposition because it means new lines of insurance. But the workingmen and trade unions, a large part, have not yet seen what this group insurance means. Group insurance means that although the employer pays the premium of 1 or 2%, yet the workingman knows that if he quits that employer he loses his insurance, and the great inducement to the employer to take out that insurance is to tie the workingman to the job, to keep the loyalty of the workingman; that reduces the ability of the workingman to leave that job and go to some other employer who is not insured. The consequence is that gradually the workingman loses his ability to demand more pay when wages go up, and gradually that 1 or 2% premium of the group insurance is shifted over onto the workingman in the form of lesser comparative wages. Universal insurance then, compulsory and mandatory, will compel all competitors to insure alike; the workingman will then be free to leave one employer and go to another, without losing his insurance. So compulsory health insurance accomplishes two things at the same time, it makes the system universal, and it liberates the workingman. (Applause.)

A SCRAP-BOOK FOR NEWSPAPER CLIPPINGS CONCERNING MEMBERS.

For some years the San Francisco County Medical Society has maintained a scrap-book in which are pasted newspaper clippings concerning members. The idea involved in this is that if the newspaper clipping is of a legitimate character, that is, of having no indication of self-exploitation, then no stigma can attach to the member. For doctors are to a certain extent subject to the same elements of newspaper publicity as are other citizens. Clippings of purely personal nature will not, of course, be pasted in such a scrap-book. Newspaper clippings of an undesirable character, however, become a matter of record.

In response to the request of a number of members of the Los Angeles Society that such a book be started for the Los Angeles County Association, the council has ordered that such a book of newspaper clippings be kept.

Newspaper clippings will be obtained through one of the clipping agencies and the books taken to the regular meetings at least four times a year and placed on the tables for the inspection of members. Due notice will appear in the *Bulletin*. Members who send in clippings are requested to write the name and date of the newspaper thereon.

The council has appointed a committee . . . . to have charge of this book. Clippings may be sent to the committee, or to any other officer of the Society, who will forward the same to the committee for insertion in the scrap-book.—*Bulletin*, Los Angeles County (Cal.) Medical Association.

FURTHER OBJECTIONS TO COMPULSORY HEALTH INSURANCE.*†

BY EDWARD H. OCHSNER, B. S., M. D., F. A. C. S.,

ATTENDING SURGEON, AUGUSTANA HOSPITAL,

CHICAGO, ILL.

I want to thank your President and the Chairman of the Program Committee for the pleasure of being with you. I also want to not thank them for having put up against me here probably the most logical and brilliant man of that brilliant institution at Madison. But I have never run away from a job, and I am not going to run away from this one.

Now Professor Commons, in his very logical presentation has made just one mistake, and that is a comparison between Compulsory Health Insurance and Compulsory Accident Insurance. They are fundamentally different, gentlemen. His plea was a splendid idea for compulsory accident insurance, but it does not apply to Compulsory Health Insurance, as I believe I will be able to show. I will say further that I have put my points down in writing, because I feel that I can present them much more concisely than by talking.

So far as I know, the first universal Compulsory Health Insurance Legislation that was enacted by any country went into effect in Germany thirty-five years ago and was the product of the fertile brain of Bismarck. He realized that something had to be done in order to stem the growing tide of socialism and it occurred to him that, by instituting compulsory health insurance and old age pensions, he could appease the proletariat and make them think that they were having a share in the government and that then they would hesitate to tear down a government in which they had a financial interest. That Bismarck was right, recent events have clearly demonstrated, for, if it had not been for old age pensions and other forms of social insurance, it is very doubtful whether the German socialists could have been driven into this war. Bismarck was a consistent, persistent and insistent monarchist believing firmly that the monarchical form of government was the best form of government and was willing to go to any length to maintain the system which he considered best,—and, yet, the very system which ultimately brought about his downfall.

In America, the movement for compulsory health insurance has an entirely different origin. A prominent eastern professor of Political Economy, some years ago became the unfortunate victim of pulmonary tuberculosis. He soon discovered that the health of an individual was an important factor in his economic welfare and that, while a study of such subjects as "Supply and Demand," "Wages and Capital," "Free Trade and Tariff," "The Distribution of Wealth," etc., is intensely interesting to the student and teacher of political economy and of benefit to the general public and essential to rational legislation, it is not nearly as important to the individual as is his own personal ability to work and earn a living. Like so many students of abstract subjects, he soon reached the conclusion that the evils resulting from ill health could be corrected by legislation. This gentleman was the chief mover in organizing the American Association for Labor Legislation, a group of estimable theorists, who conceived the idea of drafting a bill and, if possible, securing its enactment into law in every state in the union. The purpose of the proposed law was to compel every employe, whose earnings were less than One Hundred Dollars per month, to be insured against sickness. The bill, which was finally drafted and

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*Address delivered at the Seventy-second Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Wisconsin, October 4th, 1918.

†On December 21st, 1916, the West Side Branch of the Chicago Medical Society presented a program on "Social Insurance Legislation." Nine speakers participated in the discussion. Five were definitely in favor of compulsory health insurance, three expressed the opinion that it was bound to come and the best thing to do for the medical profession was to get the best terms they could. Of the nine speakers, the author of the above was the only one who opposed compulsory health insurance, and expressed his views more fully on the subject in a paper read before the North Side Branch of the Chicago Medical Society on January 12th, 1917, under the title "Some Objections to Health Insurance Legislation," published in the February, 1917, issue of the Illinois Medical Journal and simultaneously in the "Insurance Age." This hastily written article had the desired effect. The medical profession of Illinois began to study the matter and when thinking men with practical experience begin seriously to investigate this subject and check it up with their own practical experience they usually come to the conclusion that C. H. I. would be a serious mistake. This is illustrated by the actions taken by the Council of the Chicago Medical Society and the House of Delegates of the Illinois State Medical Society when they both went on record unanimously condemning C. H. I.

which by them was called the "Model Bill" had twelve important features:

1. Cash Benefits, two-thirds of wages for twenty-six weeks only.
2. Free Medical and Surgical Service.
3. Free Nursing Attendance.
4. Free Medical and Surgical Supplies.
5. Free Hospital Service.
6. Cash Benefit to Dependents.
7. Funeral Benefits.
8. Maternity Benefits.
9. Free Dental Work.
10. Free Medical Treatment for Dependents.
11. That it should be compulsory for all employees earning less than One Hundred Dollars per month.
12. That forty per cent of the cost of this insurance be borne by the employer, forty per cent by the employe and twenty per cent by the State.

It is evident to anyone familiar with the practice of medicine that such a program would entail a fearful expense because we all know that when such things as medical service and medical supplies are rendered without expense to the recipient, great extravagance results. Anyone, who is familiar with contract practice, knows that the patients who can get free service are constantly running to the Doctor, and if surgical supplies and medicine were free, they would be unnecessarily wasted. This is not theory but the result of large experience. Every physician who has ever been engaged in contract practice with whom I have spoken, and I have interviewed many on this subject, has told me that where medical services are rendered free or at so much per annum, the patients are constantly running to the physician for medical advice and medicine; however, the most striking illustration in support of this statement can be found in a recent experience of the University of Wisconsin, which some years ago went into a modified form of contract practice. Each student, by paying a small fee each year, is given medical care by the clinical staff of the University. At a hearing before the Legislature of that State at which I had occasion to appear, the Dean of the Medical School made the statement that, during the fall semester of 1915, the clinical staff made 17,000 calls and examinations on a student body of about 4,000. In other words, every student in that institution received medical attention on an average of 4¼ times during a period of sixteen weeks, or at the rate of 13¾ times a year,—or for a family of four, which is a little below the Chicago average, at the rate of 55+ times a year. When in addition we consider that this service was rendered to University students in the prime of life and health, it becomes evident that a clientele consisting of all ages would require a great deal more attention, for little babies, the aged, women during the child bearing period and men in hazardous occupations certainly would require more medical attention than do University students; but, even if we figure only fifty calls a year at fifty cents a call, it would amount to Twenty-five Dollars per annum for medical services alone. If one of the ten benefits promised by the "Model Bill" amounts to at least $25.00 per annum, per insured, it is evident that the ten will come very high. I doubt whether all of them could be rendered at $100.00 per annum. However, for the sake of argument and in order to be more than fair, let us grant that $60.00 would cover the expense per annum, per insured.

Professor Deibeler of Northwestern University, in a paper read before a sub-committee of the Illinois Committee on Social Legislation, estimated that in the State of Illinois, excluding farm laborers, there were employed at that time, eighteen months ago, 1,053,000 persons in gainful occupations in the industries of the State that received less than one hundred dollars per month. From this we have a right to conclude that it would cost at least sixty million dollars to operate a scheme of which, according to the Model Bill, twenty-four million would be paid into the treasury by the employers, twenty-four million by the employees and twelve million to be derived by taxation.

Personally, I do not think it would be fair to tax small tradesmen, shopkeepers or farmers to support such a system unless they are included in it. The small tradesman and shopkeeper is already finding it very difficult to make a decent living and practically impossible to acquire even a moderate competence for old age, because of the increasing competition of mail order houses and large corporations. The average farmer and farmer's wife, particularly the renter, are the hardest worked citizens in the State. Practically all of these classes often go without medical aid because

they cannot afford it and it certainly would not seem fair to take their hard earned income to provide medical services for others, when they themselves cannot afford it. So far as I know, all those in favor of compulsory health insurance have admitted that the system could not be maintained without State support. If this is true, there surely is here an insurmountable objection to the enactment of such legislation, for no law should be enacted which imposes an injustice on a very considerable percentage of citizens engaged in legitimate occupations.

A far-reaching innovation in our government, such as compulsory health insurance would be, must be viewed from many angles. We must consider its effect upon the general public, also its effect upon the individuals who come most directly under its influence, namely, the insured, the employer and the medical profession. The influence upon the former is, I am sure, bad because it encourages him to run to the physician for every little ache and pain, as forcibly illustrated in the University of Wisconsin experience and the experience of practically every physician who has been engaged in contract practice. It unquestionably leads to the excessive consumption of drugs and the attempt, on the part of the insured, to substitute drugs for personal hygiene and right living. He, who gets free medical advice and is paid for loss of time from sickness, is very much more likely to disregard the laws of health and to resent advice as to improvement in his mode of living than is he, who has to pay for his medical advice out of his own pocket. I think practically every physician with a large experience will bear me out in this statement. This statement is further borne out by the experience with German health insurance where the loss of time from sickness has actually increased fifty per cent since the health insurance law went into effect. In order to emphasize my point more forcibly, let us adduce some evidence from my own personal experience.

When I was a youngster, I worked two seasons as a lumber-jack. The camp in which I lived contained between thirty-two and forty men. Of this number, one only did not use intoxicating liquor, two only did not use tobacco and only about half did not use liquor to excess or have vicious habits. About half of the men spent their hard-earned money either at the saloons in the nearby town or went regularly to the Island, or did both. Those of you who are familiar with the Islands in the Mississippi River need no explanation as to what they went there for. I should like to know how health insurance, insuring these men for loss of time and providing for them free medical care, would have prevented them from doing the very things which were the cause of much of their sickness. To the contrary, I believe that a larger per cent would have gone to the Island if they had felt that they would be protected against loss of time and would have free medical care if they became sick, and health insurance would actually have increased the percentage of immorality. Various motives control men's morals. Some, and not an inconsiderable per cent, are moral because they are afraid to be immoral, because they fear that immorality will bring sickness and loss of income. Many a time I have been ridiculed for not going along with them. I have been taunted to come along and have a good time. It would certainly have been adding injury to insult, if, in addition to these taunts, I would have been compelled by law to pay the men who did go for loss of time and for their medical care. I should like to ask some one to explain to me on what theory of justice those of us who lived clean moral lives should have been taxed to pay for loss of their time and for their doctor bills for illness very largely brought on by themselves. Take, for instance, a clean-living man and one of the other kind, who on the average together will lose sixteen days a year by sickness, we are told. I firmly believe, that the clean-living man will, as a rule, lose much less time than will the man with loose morals and bad personal habits. You may say that this illustration refers to an individual case. In answer I would say, that the same conditions pertain in every lumber camp, mining camp and railroad camp and on many farms and in many factories. Possibly not at the rate of fifty, fifty, but certainly at the rate of twenty-five, seventy-five, and if it is wrong to make the clean-living fifty pay for the wrong doings of the vicious-living fifty, it is equally wrong for the clean-living seventy-five per cent to be penalized to support and maintain and provide medical care for the immoral twenty-five per cent. It is high time that in our legislative enactments we think more and more of encouraging the hard-working, honest citizen, and make it harder for the shiftless to find Easy Money.

One of the principal difficulties with our eco-

nomic system today is, that too large a per cent of our population are non-producers, drones, yes even human parasites. This scheme of health insurance would have a tendency to increase this undesirable class instead of decreasing it. The hard-working general practitioners would do all of the hard work for relatively very little pay. The political favorites would get the big salaries and hold down the easy jobs. The hard-working, self-respecting workman, who is too honest to pretend sickness unless he is really sick and too proud to take benefits unless he is absolutely sure that he is entitled to them, would pay tribute to the lazy and unscrupulous who are constantly trying to get out of work. This observation naturally brings us to the next objection to compulsory health insurance.

Free medical service and compensation for loss of time due to sickness, such as compulsory health insurance would provide, also has a strong tendency to increase malingering and to gratify the patients' desire for easy money. Some of these patients find it much more comfortable to feign sickness, to get free medical treatment, and two-thirds compensation, than to work. This statement is borne out by the experience of those engaged in contract practice, commercial insurance practice and mutual sick benefit practice, and still more forcibly emphasized by the experience of compulsory health insurance in Germany. Twenty-one years ago, I spent six months as externe at the Neue Allgemeine Krankenhause, in Hamburg, doing some work under the prominent surgeon, Professor Kuemmel. One morning, in making rounds, Professor Kuemmel told me personally that, since the introduction of health insurance laws in Germany, malingering had increased tremendously among the patients. He said that a very considerable portion of his time was practically wasted in ferreting out malingerers. If this be true in a surgical service, how much more common it must be in a medical service where malingering is so much harder to detect. The fact is, in Germany, a voluminous literature has sprung up, telling in detail how malingerers of all kinds can be detected—all of which goes to show that health insurance has a tendency to compel the honest, industrious worker to pay tribute to the lazy, shiftless and unscrupulous.

Let us now briefly consider the effect such legislation is likely to have upon the medical profession, for next to stability of government, honesty of administration and general intelligence of the people, the welfare of the nation depends more upon the quality of the medical service which is rendered than upon any one other thing. The longevity, health, efficiency and happiness of a people depends more upon the integrity, ability and industry of its medical profession than upon anything else. Anything that has a tendency to lower the standard of medical service does serious injury to the whole nation. If you are going to make the average medical man a mere drudge, robbing him of his independence, then overwork and underpay him, you are going to have a less and less efficient class of medical men, irrespective of the medical requirements, simply because the brighter men will refuse to go into a profession in which they are thus hampered. That this has actually happened in Germany, where compulsory health insurance has been in force longest, is very evident to anyone familiar with conditions there. It is a noteworthy fact, that, in the last twenty years, only one thing of prime importance has come out of Germany and that purely a laboratory matter, namely, Salvarsan: Twenty-two years ago, Lorenz published his great work on the bloodless operation for congenital dislocation of the hip: Twenty-three years ago Roentgen discovered the X-Ray: About twenty-six years ago Biering and Roux brought out the diphtheria serum. Since then nothing of clinical importance, except Salvarsan, has come out of Germany. The reason is that the practice of medicine has been made so unremunerative and unattractive that a smaller and smaller number of really brilliant men enter the profession. Who is there now in Germany to take the place of the grand old clinical masters such as Billroth, Volkman, Langerbeck, Hebra, Kaposi, Schede, Koenig, Bergman, Van Graffe, Von Miquiliz, Nothnagel, Trendellenburg, Ohlshausen, Von Leyden, Senator, Israel, and Neusser? The number of younger men of first magnitude today can be counted on the fingers of one hand. There is a reason for all this, and the reason can largely be found in compulsory health insurance laws, which have crushed independence and enthusiasm out of the medical profession. These facts I know to be true for I studied two years in Germany and Austria, talked intimately with many of their medical men among whom were some of the most prominent ones, and twenty-two years ago, I, myself, acted as an assistant for

a period of six weeks to a health insurance physician in Leipsig. I had a splendid opportunity to observe the practical workings of the system. My conclusion at that time was that either health insurance resulted in high cost to the insured, or underpay to the medical man, or inefficient service, or any two or three of these. I have had no reason to change my conclusion formed at that time. I worked in an ambulatory clinic for ear, nose and throat. The man I worked with was a splendid man, very conscientious and rendered good service to the patients, but he told me that, in spite of the fact that he had a small outside private practice of which he took care in the afternoon and in spite of the fact that he worked hard from four to five hours in the health insurance clinic every morning, he was scarcely able to make a living. The physician in charge was a man of splendid type with excellent education and an assistant in the University Medical School. In spite of these remarkable qualifications, with industry and zeal, at the age of forty, he was scarcely able to make a decent living for himself and wife and little child. If such conditions are established in this country, only men of means will study medicine, and then medical progress will surely cease.

In this country, at least, we suffer from still another serious difficulty and that is notoriously inefficient more or less corrupt administration of government. It is a very serious question whether we have progressed far enough in civilization, far enough in the administration of our government to make it safe to venture into this new field. I am afraid it would be a dangerous weapon in the hands of our spoils politicians through the State machinery which would have to be established to run health insurance. It would give to them almost complete control of a large per cent of the medical profession. The question naturally arises, "who would have to administer health insurance laws, and have we now, or are we likely to secure suitable machinery for its administration?" Shall it be the State, the City or the County, and have any or all of these political subdivisions so conducted themselves, say, during the past twenty-five years, as to make us willing to entrust this additional power to them? I have been a resident and citizen of Chicago for twenty-seven years and have watched things rather closely, politically. I am free to express the opinion that inefficiency and mismanagement have been the rule rather than the exception. The best one can say of the management of State institutions is that it is rarely, if ever, excellent, sometimes good, more often bad and still more often mediocre. Our County and City administration is usually worse. It is reported in the daily press that, during the year 1917, eleven real estate experts received $130,000 of Chicago tax-payer's money for part time service appraising real estate. I am sure every physician would like a nice fat job at $10,000 to $15,000 per year, spending three or four hours a day giving opinions and advice on medical subjects of various kinds. But there are a number of serious difficulties in the way; first, there would not be enough money to go around for all of us; second, not those best qualified but those who have the most political pull would be almost sure to secure the most desirable positions and the rest of us would have to kowtow to those political appointees or go hungry. What kind of medical service do you think the citizens of Chicago would get if some favorite of Hinky Dink or the Bath House were to supervise their medical work and tell the physicians what they might and what they might not do? Until we have devised means to eliminate spoils politics, favoritism, pull, nepotism and graft from our political life, compulsory health insurance would be one of the most dangerous ventures which we could undertake.

When Rupert Blue coined the phrase, "The next great step is health insurance," he came about as near expressing the truth as catch phrases and epigrams usually do. If, instead, he had said, "The next step backward may be compulsory health insurance," he would have come very much nearer the truth. Or again the slogan, "The Health of the Individual is a Community Problem," is only a half truth and hence more dangerous than a falsehood, because much more difficult to detect. Instead, it should be, "The Health of of the Community is a Community Problem, but the healing of the sick is a very personal matter." Most of the confusion, which exists on this subject even in the minds of medical men today, is there because we have not kept clearly in mind the great fundamental difference between preventive medicine on the one side and the care of the sick on the other. Preventive medicine should in the main be a government function because organized society, as expressed in government alone, can handle this phase of the medical problem. Pre-

ventive medicine is peculiarly suited to government control, while the care of the sick is entirely unsuited to it. The treatment of a sick person is a very personal matter and does not lend itself well to wholesale impersonal methods. To show how little some men employed by the government realize this distinction, permit me to give a concrete illustration by quoting a recent remark of a Chicago Health Inspector. This morning, April 13, 1918, a Health Inspector called on a desperately sick broncho-pneumonia patient. In the presence of the sick man, he pulled out a long list of names, patients whom he was to visit during the day, with the following remark: "Here are one hundred fifty names and addresses that I am supposed to visit today. Six were dead already when I called this morning. Sixty per cent die." This was surely splendid encouragement and an excellent tonic for a man who was just on the brink. April 14th. This morning the patient was dead. What part of the result was due to the Health Inspector's remark, no one can tell. A private physician who would make such a senseless, brutal remark in the presence of his patient could not do much harm, because he would have few, if any patients. While such an individual can do untold mischief when he once gets into the public service, because if he will obey the department rules, flatter his superiors, and regularly come across with campaign contributions, it is almost impossible to separate him from his job.

He who thinks that all there is to the practice of medicine and surgery is a knowledge of the action of drugs and a certain skill in the handling of surgical instruments is as far wrong as he who thinks that all that is worth while in life is money and what money will buy. The successful practice of medicine depends fully as much upon the personal human sympathy which exists between the physician and his patient as upon the scientific problems involved, and if you take away the former and commercialize and wholesaleize the practice of medicine, you will alienate from it a large proportion of the big, whole-souled, humane men who have made medicine what it is today.

Those, who are so strongly in favor of health insurance legislation seem to be laboring under still another misapprehension. They seem to think that health insurance will either prevent poverty or cure the evils resulting from poverty. I feel, however, that it will do neither; that, in fact, health insurance would be only a palliative and like most palliatives, if persistently employed, will do more harm than good.

The present agitation for health insurance reminds me very forcibly of the medical experience with the hypodermic use of morphine. When the hypodermic use of morphine was first introduced, many laymen and even some physicians were very enthusiastic about it and felt that now a remedy for the banishment of all pain from the world had been discovered. Gallstones, for instance, had lost their terror temporarily because a simple injection would almost instantly still the pain. It took even physicians some time to realize that morphine was only a palliative and if persisted in the patient was eventually actually made worse instead of better. In order to cure the patient, much more heroic means must be resorted to—the gallstones must actually be removed with the knife.

While pain and poverty will never be banished from the world, pain has already been greatly alleviated, because medicine has largely substituted prevention and cure for palliation. Are we going to make the same mistake in attempting to relieve poverty that we made in attempting to relieve pain? I hope not. I hope instead we will strike at the root of the evil, prevent most of it, cure a large per cent of the remainder and palliate only that which cannot be prevented or cured.

The American laboring man does not want charity nor does he want his life regulated for him from the cradle to the grave. He wants an opportunity to work out his own salvation. He wants to be able to choose medical advice for himself and his children unhampered. Let us at least be consistent. If we believe in autocracy, let us have it. If we believe in socialism, let us have that, but, let us not attempt to graft a cross between autocracy and socialism upon our democratic institutions. I am a thorough believer in democracy, and I believe that in a true democracy the individual is not only permitted, but encouraged to do that which he can do best, while the State undertakes to do that only which it can do best. Healing of the sick is a very personal matter and best accomplished by the individual. The State, on the other hand, should devote its attention to Public Health and sanitation and general instruction in personal hygiene. In addition, it is the duty of the State to see to it that every medical man who possesses a license to practice is remarkably effi-

cient and reasonably honest. Here the function of the State ends in a true democracy.

The burden of proof is clearly upon those who are in favor of Compulsory Health Insurance. To show that certain evils exist is not sufficient. They must be able to prove beyond a reasonable doubt that the remedy which they suggest will cure these evils and that it will not introduce new and even greater evils than those it is intended to remedy.

I agree that statistics, if carefully and conscientiously collected, do not necessarily lie and, yet, when it comes to the more subtle human relations, they rarely ever tell the whole truth. It is for this reason that I have brought out here so many of my own personal experiences, experiences which all speak against compulsory health insurance. This has made it necessary for me to leave out many of the arguments usually given against compulsory health insurance, such as the fact that it would not solve the problem of the pauper or the occasional worker, for no one, not even the most ardent supporters of compulsory health insurance has ever claimed that any clause could be incorporated which would solve this difficult problem. In fact, they are forced to admit that the burden of their care, which has heretofore been voluntarily borne by the physicians, would have to be assumed by the State at an expense which would run into the hundreds of thousands of dollars.

In conclusion, I firmly believe that to establish compulsory health insurance would be one of the most serious mistakes that any commonwealth could possibly make, because it would be bound to lower the quality of medical services rendered to its citizens, it would increase loss of working time from sickness, it would throw an enormous financial burden upon the tax-payer, the employer and the employe, it would greatly reduce the incentive to thrift and industry and put a premium on deception, sloth and shiftlessness, and compel the industrious, hard-working, clean-living, workman to pay tribute to the untruthful, hazy, shiftless and immoral, and finally, it would have a tendency to take from independence and self-reliance its proper pride and from dependency its salutary shame.

DISCUSSION.

Dr. Charles H. Lemon, Milwaukee: Mr. President and Gentlemen. These are two most interesting statements from two opposite angles, and I wish to endorse everything that Prof. Commons has said here this morning. I think that Dr. Ochsner has taken the position that he has because of a bill introduced by the Society for Labor Legislation, which I studied carefully as a member of the Committee on Health Insurance of the State Medical Society, and which I think is Utopian in its ideals and thoroughly impractical of application. I think that the views of Dr. Ochsner and Prof. Commons could be reconciled if certain things were accepted by those interested in this legislation, and that this matter of health insurance could be put through, to the benefit of the medical profession, as well as to the benefit of the industrial laborer, because it does not apply to anybody else. Prof. Commons said that he was not in favor of paying wages for a man that was sick, either two-thirds or anything else, because it was encouraging malingering. I believe that to be the fact, from personal experience.

I have had some 7 years experience with health insurance—not a health insurance that was compulsory, but a health insurance that was voluntary. I said something before the Society two years ago, and also a year ago, on this subject. Now, Gentlemen, the Milwaukee Electric Railway & Light Co. has approximately 4,000 employees. Every employee of that Company belongs to a mutual benefit association. Every member pays 50c a month into this, we will call it, insurance fund, and the Company pays an equal amount. During 7 years we have had a gradual evolution of medical activities. We began in a rather guarded way, but from year to year those activities have been extended, and the medical benefits have been extended; so that today, at the end of 7 years, every employee, his wife, his children, or his dependents, receive the entire medical and surgical treatment that they need. But the employee is paid only a dollar a day when he is sick; the wife and children do not receive a benefit. He certainly does not receive two-thirds of his wages.

Prof. Commons did not state the law accurately when he said that the man received two-thirds of his wages. He receives two-thirds of a wage based on a maximum of $720 a year, which is about $9.50 a week, or $9.75, under the workmen's compensation law. Under the health division, he receives $1 a day if he is sick for more than 7 days, and that is continued for 100 days. At the end of the 100 days he then receives 50c a day for 100 days more. If at the end of 200 days he is incapable of further service with the Company, he receives a final payemnt as a member of the Association, of $150. That is the rule for everybody.

Dr. Ochsner spoke of the general maintenance of health, preventive medicine, as a function of the Government; but how can the Health Department of the city of Milwaukee practice preventive medicine with a dozen or two employees in a population of half a million. It cannot be done.

When this Benefit Association of the Street Railway Co. was formed, during the first two years, we simply took care of the men themselves, and we took care of them on a voluntary scheme entirely; that is, they were

at liberty to employ any physician they wished, but if they wished the services of the Mutual Benefit Association physician, all they had to do was to ask for it. I found at the end of two years that the requests for services were not commensurate with the sickness that we experienced. Now a new idea came to us, and that was to place a medical men in each of the car stations and shops of the Company, which were situated at the four corners of the city, and to the west of the city. The result was almost unbelievable. I found that these men who were grouped in large numbers, from two to five hundred each, would go and consult the physicians. I do not know how many times a year they consulted them; I could tell you, as we have the statistics, but I know that none of the physicians employed by this Association have made any complaint of the large number of men that came to see them; but I do know this, that in the year 1916 the average day's disability for workmen in the United States, as stated by the Bureau of Labor Statistics, was 9 days per year per man. Now you remember that in 1916, in the month of January, we had a severe epidemic of the grip in Milwaukee—not like this present epidemic, but still a severe epidemic which laid men up from 3 or 4 days to a week. By this intensive supervision of these men at their car stations, in the year 1916 the average days disability for all employees of the Milwaukee Electric Railway & Light Co. was about 4½ days per man per year.

We find that the man who has a little cold will come and get something to relieve it, or the man coming down with rheumatism, or some other disabling disease, will come and get that preventive treatment, or that suggestion as to change of his habits, which puts him back quickly into the industry. And to my mind that is the most important feature of our work. And I find that the number of men that consulted these physicians at their offices in the car stations and shops was in the proportion of 3 to 1 of those who called them to their houses. So that I think that in that percentage alone we have some encouragement as to the value of preventive treatment.

On the basis of a payment of 50c per month, duplicated by another 50c paid in by the Company into this fund, in 7 years, after paying death claims of $300, after paying a dollar a day for each day the man is sick over 7 days, after paying the salaries of the physicians who are employed, we have accumulated a reserve fund of something more than $60,000. And as this fund became large, we increased the benefits to the workman. Only the 1st of September of this year we included obstetrics in our scheme of treatment. So that today we have two visiting nurses; we have eight doctors; we have a hospital room in the Public Service Bldg., where all injuries occurring off duty, are treated; we have practically everything that could tend to improve the general health of the people in the employ of the Milwaukee Electric Railway & Light Co. And now we have added the matter of obstetrics. I, for one, was afraid of the obstetrics, because I knew it would tie a man up. I thought a medical man would not be able to keep up this routine work with the obstetrics. So that in order to take on the obstetrics we have taken on another man.

Now let me give you some of the figures: For the year 1917 all the activities in a medical way, surgical and medical, based on a dollar per visit of a patient, and a maximum of $100 for a major operation, what we did for the employees of the Milwaukee Electric Railway & Light Co. amounted to $38,000. Now what did it cost? Dr. Ochsner is afraid, and hopes that he will never see the day when doctors will get less than 50c a call. That Association paid to the doctors in its employ this last year, $28,000.

Another point: Has it in any way reduced the efficiency of the medical men? Answer: It has not. I think my own efficiency has been increased since this Mutual Benefit Association became a part of my duties as chief surgeon for the Company, and I have been with the Company some 23 years. It gave me a line of work that I did not see before, because while I am not a full time man, and never would be, some of my friends here in the city rather gave out the impression that I was not available as a surgeon, because I was working for the T. M. E. R. & L. Co.; and as I was working entirely in the surgical field, it was rather easy for me to lose track of these medical cases; and I have really reveled in the opportunity that was presented to me to study the vast number of diseases that these men and their wives and children have presented. So I feel that if a scheme of Medical insurance is put in force by the state, and made a matter of law, and I believe it is coming, and I do not believe it could be stopped, I believe the time will come when those who are opposed to it, as Dr. Ochsner seems to be, most emphatically, will see that there is some good in it. Now I am not speaking this morning for the Milwaukee Electric Railway & Light Co. I do not know what their policy is with reference to a state insurance fund. I never discussed the matter with them at all. All that we have discussed has been with reference to our own employees. And Mr. Mortimer, the president of that corporation, I think has taken a very broad view of this whole matter. He has not desired to accumulate a lot of money for somebody else to spend, but has taken the interest of that money and added a new doctor from time to time. We haven't a physician in our employ who is a full time man. We haven't a physician in our employ whose work for the benefit of the Association takes more than half, or in the busy times, two-thirds of his time; and we haven't a man in our employ in the city of Milwaukee who is receiving less than $3,000 a year for his services.

Dr. H. E. Dearholt, Milwaukee: Mr. Chairman and Gentlemen. As a former chairman of the official State Committee on Health Insurance of the State Medical Society of Wisconsin, and a present member of that committee, I should like to say just a word, because there has been a great deal of misunderstanding on the part of the members of the Wisconsin Medical profession and the members of this Society concerning the position of that committee.

Two years ago the House of Delegates went on record as being unanimously in favor of the *principle* of health insurance. It appointed a committee to look after the interests of the members of this Society. That committee has had many meetings, and has studied the proposition very seriously. That committee is today unanimous in favor of the *principle* of health insurance. The more the committee has studied into it, the more firmly convinced it has become, as Dr. Lemon, another member of the committee, has suggested, in favor of the principle. Every objection that Dr. Ochsner has raised to health insurance I think we all agree with. Every danger that he has suggested has, I think, been considered by that committee. We agree with the principles and the position taken by Prof, Commons, and by Dr. Ochsner. We do not quite agree with Dr. Ochsner's conclusions.

Until this Society rescinds its action, your Health Insurance Committee officially represents you; and yet the members of that committee are put in a most embarrassing position, as I can illustrate by an experience at the official hearing of the Madison Legislative Committee, when a member of this Society went to that official body and said that there are only two doctors in the whole state of Wisconsin who are in favor of health insurance principles, and those are Gray and Dearholt, Gray, because he had only a silk stocking practice, and did not know anything about poor people, and Dearholt, because he saw in this another method of bringing more tuberculosis patients into the net; and then he proceeded to argue his objection to some little detail in the management of this proposition. Now God knows that I do not know enough to see health insurance through from start to finish, and I should hate terribly to have the responsibility of putting on the statute books today a bill which would for all time attempt to solve all the problems that are going to come up in this question. It cannot be done, and it should not be attempted.

One of the most valuable contributions that Prof. Commons has made to social legislation is that attempts should not be made to solve difficult problems of this sort by hard and fast laws. That principle was put into effect in the Wisconsin Industrial Commission. It was that regulation of matters of this sort must be handled from day to day, and that the administration must meet actual conditions that cannot be anticipated in advance, as they arise. Again, every objector to health insurance puts every proponent of the principle in the position that he must accept and defend every position taken by every other proponent. I should terribly hate to be responsible for all that the American Labor Legislative Association has said in favor of it. But that is the position we are placed in all of the time, and it is unfair. It is unfair for medical men to put the members of their official committee in this unfair position. We are put in the position of being the "Devil's advocate"; it is not square.

I want to say just two things more: We know that there is a tremendous waste going on under the present system. We know that it is a part of waste that we pay for things that we do not get and that we do not have. Talk about health insurance being costly? Of course it is going to be costly. Everything in the world that is worth anything is costly. Just at the present time we are paying for it without getting it, just as in the past families have paid for food that they did not eat, as we are learning now. Too much has gone into the garbage pails.

The other thing I want to say is to endorse Prof. Common's statement about Mr. Hoffman. I think that Mr. Hoffman's arguments against health insurance are about the best arguments that I know of in favor of it. I know Mr. Hoffman very well. I meet him nearly every month, and we spend one to three days together. I have always respected Mr. Hoffman as having one of the most beautifully drilled, on the square, scientific brains of any man I ever knew; and this is the only subject I have ever known where Hoffman's arguments and figures will not stand probing right down deep to get the truth. Hoffman has, for the first time, it seems to me, in my experience with him, put out statements that do not balance with the man's unusually wonderful scientific accuracy.

Dr. George C. Ruhland, Milwaukee: Mr. Chairman, and members of the Society. I appreciate that the hour is getting late, and I hesitate taking up your time on this matter. However, being in the Public Health Service, obviously this subject is very close to our interests. I have given the matter some thought, particularly so as it appears that this state's legislature now has before it the consideration of adopting some form of health insurance. I think it is a very good thing to discuss the general subject, and I for one would like to go on record right here as saying that I believe that the question in the broadest aspects has decidedly good features. Unfortunately however, it appears that we have for discussion, and relatively for adoption in this state —and that interests me as a taxpayer in this state— something that is based on the so-called ideal law of the American labor legislation, and there is where I think some of us disagree decidedly. I was very glad to notice that Prof. Commons qualified the bill as he did in stating very definitely that he does not believe in the payment of part wages. That, I believe, is fundamentally wrong. I think the argument that frequently is advanced by the advocates of compulsory health insurance is, that it was similar to the Industrial Insurance, and that by reason of the fact that the employer, by being obliged to pay compensation for accidents that occurred in his shop, was forced to put in protective measures, does not make a complete analogy. The things are different in this, that in the one instance the employer can provide a definite mechanism that will protect against injury, and in the other instance, you put it up to the individual to do the thing that will keep him well. There you have two very marked divergent elements. Using a homely simile, if you please: you can lead a horse to water but you cannot make him drink. Merely paying for injury or for sickness when it hap-

pens is not going to reduce the disease incidence, and that has been the experience of the countries where it has been in use. Obviously then, our efforts must be in the direction of educating the public into a better understanding of these matters of personal health, which today we recognize are the biggest factor in protecting inductry and the national assets of the country, own man power.

I disagree with some of the remarks made by Dr. Lemon to the effect that such educational work could not be the function of the Health Department. It is obviously and essentially our business to do so. We already teach personal hygiene in the schools, teach prenatal work, child welfare, we arrange for opportunities so the mother can be taught in the science of home care for the sick. There must, however, be more of this educational work. In this way only will we materially reduce the incidence of sickness. To merely pay a premium when sickness has come is obviously going to fail. The official report, for instance, of compulsory insurance in England—and I am not quoting Prof. Hoffman, so often held responsible for the things that are apparently not acceptable, but Mr. Wm. A. Brend, is to the effect that compulsory insurance in England has been a palliative only, and does not strike at the root of the trouble. It is for that reason that I believe our efforts must be first of all on the educational side. Until we have tried out these things I would hesitate to commit myself to a program which is bound to carry with it big expenses. The experience in foreign countries has been that invariably the expenses are larger than was anticipated. That is why I should at this time go on record as not sponsoring a Health Insurance bill such as is proposed by the American Labor Legislation plan.

Dr. P. H. McGovern, Milwaukee: I am loth to say anything on this subject, because I do not know so very much about it. I notice that the speakers, aside from the two who have come here prepared, and have thoroughly digested their subjects, represented one particular class, namely, those who are not in competitive practice. Dr. Lemon is not in competitive practice of medicine and Drs. Ruhland and Dearholt are not practitioners. Therefore, their opinions cannot weigh with the general profession, and cannot be taken as worth anything when looking to the future of the medical men of the country. As has been said, the inducing factor that has caused brainy men in this country to enter the medical profession has been the great open competitive field for high class service with good remunerative returns to the man who could under competitive law deliver the goods.

Dr. Lemon's experience cannot apply to the law as it is proposed to have it enacted. Remember that Dr. Lemon is working in a small organization in this city where he has authority as a member, and as an official of the corporation. And remember, when you make this law state-wide, the man who makes the calls or performs the operation, has practically no personal interest in the patient except as such patient represents a biologic unit. Dr. Lemon has in his organization a deep personal interest in the welfare of all men under his charge. Besides this Dr. Lemon can exercise a potent influence within his corporation. Last spring I was asked by an East Side woman where I am family physician to go to see a child, whose mother was her scrubwoman and general housecleaner. The mother was fretting a great deal about her child, and wanted to know if I would examine it. I asked who was treating the child, and she said that the husband was working for the Milwaukee Electric Railway & Light Co., and that their physicians were taking care of it. I said that I doubted the advisability from an ethical standpoint of going in where another man was in the case, but I telephoned to Dr. Lemon, and he said, "Go right ahead and see the case, we have no objection." I examined the child, who was three years of age, and had been sick for some time with a severe broncho-pneumonia. Up to that time the chest had been aspirated three times, with negative results. I went over the chest very carefully, and could not see that the patient had anything but an ordinary broncho-pneumonia. She was in fair condition, and therefore, I advised the mother that I thought the child, under the care it was getting at the time, would get well. As I saw no dangerous symptoms there was no cause for worry. Now look at my position as a general practitioner. Beyond giving them a little salve in the form of encouragement for the future, I could not utter one word of direction; neither could I, if necessary, write a prescription, or direct other method of treatment.

Dr. Lemon: Why not?

Dr. McGovern: Because my hands were absolutely tied, as a gentleman and an ethical physician; with the case in the hands of other physicians, it would be unethical to interfere.

Dr. Lemon: Could you not have taken charge of it?

Dr. McGovern: No, I did not wish to do that. I am not in the stealing business. Remember, the father was working for the T. M. E. R. & L. Co., and he had paid for the physicians, and they are as good physicians as I am. The mother was fretting about the probable outcome without reasons for her anxiety. Why should I step into that case? Why should I utter a word, except a word of encouragement? My hands were tied. Now, Dr. Lemon, when 80 per cent of the people of this state including the farmers, come under this form of contract treatment, where the physician has not the interest and support that you have today with the T. M. E. R. & L. Co., what are the rest of us going to do with the 20 per cent, and what are we going to do when we are called in to handle the 80 per cent? Don't you see, you are putting us in a position where we cannot practice medicine outside of the contract line; it is an impossibility. And the day is not far off when the 20 per cent in Milwaukee will have to go to some other source besides the men practicing in Milwaukee today. The present practitioners will turn to other remunerative lines; they will use their brains in manufacturing and in business, where

money is made. And young men of energy and brains, will not put in $5,000 and 8 years of their adult life in preparation, to say nothing of the years which they ought to spend in hospitals before they go into practice, and then treat 20 per cent of the people of this state. I personally would never have entered the practice of medicine if I thought I was going to become a hired man. No $3,000 a year can buy any forward looking man to be content with a wage system under contract. We all desire to serve society and our country, but our environment must not hamper us at every turn. I will ask you if Dr. Ochsner's gloomy picture of medicine in Germany will not fall true here under this new dispensation. How long will present roseate conditions last, and when will the dark clouds of despair settle down upon us? How long will men of education, moral worth and industry continue to hear the call to duty in the medical profession?

Let us turn to one other phase of the subject. We love the democratic society in which we live. We should like to see society in this country a quarter of a century from now better than it is today, and Milwaukee a better city to live in than it is at present. Taking away from the workingman his power to do voluntarily, everything that he ought to do in maintaining a clean inspiring home for himself and family, will not make the worker a self-respecting and self-supporting man. Is this not better than to say in effect to him, "go ahead and contract gonorrhoea and syphilis; spend your nights in drunken bouts, be out to dances until all hours in the morning, be out joy-riding every night, you are going to be cared for by the public." Is it not better to place the responsibility just where it ultimately must rest, on the shoulders of the worker, if you are going to get results? Remember, your scheme is not new. Rome tried this thing many years ago, and the citizens of Rome degenerated. She took from the masses that precious ideal, that under just social and economic conditions every healthy citizen should by his individual exertion support not alone himself and family but also sustain and defend his state. Rome's failure to develop a virile self sufficient citizenship cost her liberty and her high civilization, when the Teutonic hordes bore down upon her, like the present militaristic Nordic overflow. Then there were no Roman citizens to rise up and drive back the hordes. There was no Cincinnatus then to leave the plow because the forests had reclaimed the tilled fields even to the walls of Rome. And every time we take away from the citizenship of this state those elements that go to make for manhood and womanhood—the individual right to do for themselves—we strike a blow at the foundation of society. Responsibility rests upon the citizen naturally. He is to rely on nobody, so long as he can command a position of service. So long as society places those opportunities before him, he requires none other, and an honest man will receive none other. He wants no charity, he wants a square deal, he wants laws that will secure to him the entire fruits of his labors. Instead of taking away his self-respect and desire to work his own salvation, remove from his path snares and temptations. By banishing the saloon you can directly and indirectly set up a clean, wholesome home and thus cut out one-half of all the disease in the state, and most of the squalor and suffering. Go to the masses with the beauties of a simple, clean life and preach to the people of this state on the subject of home economics, on how to look to their personal hygiene, how to make the home worth having. This question is not a matter of a law that is to be passed, and by that law make a perfect society. It means the opening of our eyes to the immense problem that is before us. We have a wonderful educational program here. Let us take up this problem, and spend some of our money in this line of work. Let us, as I said at the very beginning, banish the three great evils that are sapping the vital forces and the economic income of our people, the beer can, the garbage can, and the motion picture house. When we have gotten rid of those we will be putting our families in a position where they, economically at least, can get for themselves the things necessary to maintain a proper home, to clothe and educate their children, and to place before them the high ideals that all should strive to attain. The old methods of the school, the public lecture, the church, are the agencies upon which we must rely, if we are to build any abiding social reform.

Dr. E. H. Ochsner, Chicago, Ill.: Mr. President and Gentlemen. I think a few of the statements that were made in the discussion ought to be emphasized somewhat. Let me say again, that the problem of compulsory health insurance and the problem of accident insurance are as different as day and night. One is compulsory, the other is not compulsory. One the state must provide for, in part at least, and almost all authorities agree that the state must provide not less than 20 per cent of the total. If it is necessary for the state to provide 20 per cent, that alone should kill the proposition absolutely. If that is not necessary, then one objection is removed. At a hearing which I was asked to attend not long ago, one of the members asked me if the farmers often lack medical attendance when they should have it, and I answered yes. Why should they pay 20 per cent? It is not right. I could give many illustrations in support of my answer, but many of you gentlemen are in general practice and you know yourselves that that is true. Accident insurance insures against accidents which occur while the workmen are at work, and where the employer has a responsibility, but ordinary sickness occurs more often as the result of home conditions, because the people are at home 16 hours out of the 24, and it is the home life and the home environment that makes the difference. Gentlemen, if you will spend 10 per cent of the money that it is proposed to spend for compulsory health insurance in good serviceable, workable health laws which are administered by your city and state health departments, you will get the very things that you are asking for at 10 per cent of the expense. Every single thing that Dr. Lemon said that his company did for his employes that was worth anything at all, was their health advice, was their sickness preven-

tion, and not sickness cure. I dare say that those same employes that they take care of would be better taken care of by the physicians of Milwaukee than by them. The great service that these companies render is in the prevention of sickness, the telling a person when he is sick enough to seek medical advice. And a few of the great corporations in this country are beginning to see the light of day. There are today great corporations in the city of Chicago who are contemplating abolishing the treatment of their employes and devoting all of their time and all of their energy to sickness prevention. I have no doubt that Dr. Lemon has just as good men on his staff as there are in the city, but they do not have the same influence upon the patients. They are paid by the company, and they serve the patient for nothing. When I serve a patient for nothing, usually my service is valued at what I get for it, and that is the reason these people go to other doctors when they really get sick. He cannot pretend to make us believe that his 8 part time physicians are taking complete care of 20,000 employes and their dependents. They do not do it. The great majority of that home care is done by the Milwaukee physician. And what is the result? When the proposition becomes compulsory, the employe will have to pay the physician, and then when he gets really sick he has to dig down in his own pocket and pay the physician he wants to treat him.

I feel about the matter a good deal as Dr. McGovern does. Another 10, 15, 20 years, and most of us who are here today will be out of the practice of medicine. It is all over in the twinkle of an eye. But I should like the young men of the next generation to have the same chance I had. If I would have had to pay $25 a year out of my pocket for compulsory health insurance, which I did not need, I would not have been able to get my education. Gentlemen, it would have prohibited me from getting my education. I worked for $17.50 on the farm from 5 o'clock in the morning until 9 o'clock at night to get my education. If I had been compelled by law to pay $25 annually into the state treasury, I would have considered it legalized robbery, and I would consider it robbery today. I want the future young man of the common people to have the same chance to get ahead and get his education that I had. And, Gentlemen, after all is said and done, the poor men's sons are the ones who have made medical progress in the world, and not the man who got his medical education with silver spoons.

INDUSTRIES OF UNITED STATES URGED TO FIT THEIR EMPLOYEES TO POSITIONS FOR WHICH THEY ARE PHYSICALLY BEST SUITED.

Samuel Gompers, chairman of the Committee of Labor, has recommended to Secretary William B. Wilson of the Department of Labor, that medical examination of applicants be made one of the functions of the government labor recruiting agencies. This recommendation, reports *The Modern Hospital*, was the outcome of a conference recently held in New York under the auspices of the National sub-committee on welfare work of the Committee of Labor.

The context of the resolutions adopted at this time was that the physical examination of workers is essential as a health conservation measure, that the purpose of the examination was not to debar the worker from industrial service, but rather to see that he rendered the maximum of service by being placed at work for which he was physically best fitted. Medical examination cards will be issued by the government recruiting agencies indicating the health of the worker and classifying him according to physical fitness. By this method it is believed that communicable diseases will be early discovered and eradicated, their spread prevented, subnormal employees placed in occupations suited to their peculiar conditions, and the employment of those physically below par made possible.

PRIVATE OR OFFICER, WHICH?

The daily press of a few days ago announced the fact that on one day, during the last movements of registrants, forty-two doctors were received at Jefferson Barracks, as privates, sent there with the rest of the drafted men. These physicians came from Missouri, Kansas, Iowa and Illinois and all had had ample opportunity to apply for admission in the Medical Officers Reserve Corps, but failed to do so. Being within the age limit, they were found physically fit for general military service and as their order numbers were reached, they were entrained and sent to camp. All of these may have become privates by preference, but their services would have been more valuable to the government as physicians than they ever can be as men on the line.

PATRIOTIC AND HEALTHFUL HEATING.

Men, women, and children—the weak and the strong, are working in unison to win the war. Even those who are so ill as to be confined to the hospital will not be slackers if the hospitals follow the plan outlined in the October *Modern Hospital* by the United States Fuel Administration. Among the general rules given in the article are the following which are applicable alike to hospital and home:

1. Storm windows and storm doors, weatherstrips and other protective devices should be provided.

2. It is wasteful to allow the temperature of a room to go *too low* at night because a great deal of fuel is required to raise it in the morning.

3. Use your thermometer and regulate the heat. Much coal can be wasted by guessing at temperatures.

4. Know your heating plant and regulate it thoughtfully.

5. Keep your heating plant absolutely clean.

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ROCK SLEYSTER, M. D., Editor
Waupun

J. P. McMAHON, Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:

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EDITORIALS

RED CROSS HOSPITAL WORK.

THE work of the American Red Cross in the hospitals of France divides itself very distinctly into two types: work for the French people and work for the American Army. The latter is of course paramount. The health, the welfare, the morale of our soldiers must be carefully guarded, and here the Red Cross works hand in hand with the military authorities. It is the army's emergency depot, storing vast stocks of comforts and necessities—surgical dressings and cigarettes, magazines and games and delicacies for convalescents,—hundreds of things, tons of things, ready for immediate delivery if the army calls for them.

Twenty-two base hospitals have been equipped and organized; rest stations and infirmaries established along the line of troop movements. The Red Cross has three magnificently equipped hospitals which are operated for the American and French armies; and supports, in the interest of the French, five others,—supplying ambulances, beds, medical and surgical supplies and part of the personnel. Aside from what is being done in this way in our own army, hospital supplies are being furnished to over 3,000 French hospitals.

In each of the American army hospitals is a Red Cross representative who follows every engagement and supplements the information received from the government by the families of the wounded, killed or missing. He forms a link, at need, between the enlisted man and his family at home, and looks after his comfort and general welfare. Recreation huts are also being erected at the base hospitals, and diet kitchens have been established to furnish to the badly wounded delicacies not on the regular hospital list.

Among the French population, particularly from the areas overrun by the enemy, a tremendous work has been done, involving the expenditure of over $21,000,000. The French children, practically all of whom are undernourished, have required special care if the nation is to survive the frightful strain of war. A children's hospital has been established at Evian through which point the repatriates are returning from Germany. A medical center and traveling dispensary takes care of twelve hundred children at one point in the devastated lands; at another, a children's refuge and and hospital has been opened.

To combat the ravages of tuberculosis, that scourge of impoverished peoples, a series of three hundred dispensaries is being established throughout France, and many hospitals have been equipped and opened. The largest of these is the sanatorium remodeled out of the ancient Chateau Plessis-Piquet, which dates from the time of the Crusades. This is known as the Trudeau Sanatorium and will accommodate 200 women and children. Nearby is Malabray, a 135 acre farm, where a sort of model village will be laid out, large enough to accommodate 400 families. Here, as at many of the other hospitals, prevention and cure go hand in hand.

But figures, statistics, the number of millions

spent on hospitals, on supplies,—the number of refugees supported—none of these things can give an adequate idea of the extent, the difficulty, or above all the value of the Red Cross work in France. It is, after all, an intangible thing that the Red Cross gives,—intangible, but more powerful, more dynamic, than anything else in the world. It is service, disinterested human service, backed by the biggest thing in the world: an idea, —an idea in the heads of a hundred million people.

For although the actual membership of the Red Cross is only twenty-two million, there are a hundred million people in these United States. And it is the aim of the Red Cross in its Christmas Roll Call, which is to be held in the week beginning December 16, to make all these hundred million actual members of the organization,—to take their dollars and their signatures as a pledge of loyalty to the American ideal, so that America shall be 100% Red Cross,—shall be put on record as standing squarely and uncompromisingly for mercy, honor and good faith among the nations.

THE IRRITABLE HEART.

THE war has taught us many new facts and has focused our attention anew upon many old facts seemingly forgotten or neglected. All remember the classical paper of DaCosta on "The Irritable Heart of Soldiers". This world struggle with its terrible weapons and exhausting living and fighting conditions has brought again into light DaCosta's work. The cases studied so carefully by Lewis and his associates in England known in the English Army as D. A. H. (disordered action of the heart) have materially assisted in bringing to our notice possibly potential cases in civil life. This is the burden of my text.

The next draft is imminent. Many an examiner will again be puzzled to know what to do with the man who has a fast heart or one whose heart may beat around 90 to the minute while quietly seated but on standing will rapidly increase to 110 or even up to 140 beats per minute. Such cases are not so uncommon. Ordinary tachycardias due to the excitement of the examination may oftentimes be detected by having the subject inhale deeply, hold the breath for ten seconds, exhale strongly, hold again at exhalation for 5 to 10 seconds, then breathe naturally. Excitement tachycardias are thus steadied, so to speak. They have no significance.

After one has eliminated pathological causes of tachycardia such as pulmonary tuberculosis, myocardial degeneration, hyperthyroidism, exophthalmic goiter, acute infections, convalescence from recent disease, chronic focal infections, there still remains a puzzling and most important group. Men in this group appear, as a rule, healthy and robust, although many are of the long, narrow-chested type with enteroptosis. They have a wearisomely similar history. The condition dates back years, even into childhood and often follows some serious illness. They never could play hard. They were easily made breathless, became easily exhausted, became dizzy on exertion, had pain over the heart often quite severe. They frequently fainted for no apparent reason. They were nervous, easily excited, never did hard work but voluntarily sought easy, usually sedentary work. Some changed occupations until they found those at which they could work all day and earn a living. Frequently the family was "nervous", one or both parents were alcoholic or in an insane hospital.

When these men are exercised, the response to such an exercise as hopping on one foot 100 times exhausts them out of all proportion to the character or severity of the exercise. They pant, have an anxious expression, grasp the chest as if to hold back the pounding heart which seems ready to burst the chest wall. They often break out into a cold sweat. No one seeing these men can doubt that they are actually suffering. While examining these men their hands and feet are cold and clammy, while from the axillae the sweat runs and drips on the floor. These are the cases of irritable heart or effort syndrome or neuro-circulatory asthenia (N. C. A. in army parlance) descriptive names representing a group of symptoms the true pathological nature of which is still to be discovered. They are not normal. They are poorly equipped by nature for the race of life. They should be unconditionally rejected. They never make soldiers, they are a drag on the fighting force. Occasionally one who is expert at some sedentary work at which he has earned his living in civil life may be taken in for Limited Service.

During the last draft hundreds of such men were sent to training camps only to serve a short

while and then be discharged by the cardiovascular boards.

The symptoms are not always so outspoken as the description given above might lead one to believe. It is in the mild forms of this disorder that so much difficulty exists in placing these defective men.

That the great majority of such cases can be detected by the Examiners on Local Boards and Advisory Boards we are quite sure provided that they are on the look-out for such cases. The government will be saved many hundreds of thousands of dollars if the watch is kept keen and these potential breakdowns are kept out of the service.

L. M. W.

COMPULSORY HEALTH INSURANCE.

2. THE ECONOMIC STANDPOINT.

THE protagonists of Compulsory Health Insurance tell us that the wage-earners lose $600,000,000 a year from illness alone and for this loss there should be compensation. We grant that there is a loss and possibly it may be figured out in dollars but to reimburse partially the laborers would not be a saving. A man who loses $18 a year on account of illness and is reimbursed $6, is still out of pocket. Ah, but, it is said, his medical care, nursing care, hospital care, etc., are all paid for. Who pays? Again the dear public is asked to add one more burden to its already overloaded shoulders. What causes most of the sickness among the workers? Two conditions chiefly. First is underpay which forces poor living conditions, second is exposure to preventable infectious disease.

Now, some people are clamoring loudly for the old method of care after disease is present instead of prevention, so that disease does not come. Energy directed to a substantial betterment of the wage and city health departments would seem far better methods. The worker would then be a self-respecting citizen able to take out his own Insurance in any company he should so choose. He would not be rated on one or the other side of an arbitrary figure and compelled to do what he might not desire to do.

This raises the very important question of the enforcement of such a Compulsory Law. The plan contemplates the inclusion of about 80 per cent of wage earners, i. e., farm hands, domestic servants, etc., etc. Suppose such a law is passed would the police be summoned to arrest the recalcitrant worker who deliberately refused to be the recipient of all the joys of Compulsory Health Insurance? Suppose the man had no property against which the State could levy (and not many workers own property), would he be confined in jail until he grew docile? Would he be reimbursed for the time lost while in jail? Suppose he continued to be obdurate? Then what? Can one conjure up a picture of a horde of constables dashing from place to place trying to enforce the law against farm hands? But, it is answered the workers in factories will have to come under the act or lose their jobs. It can only be rejoined that such compulsion savors of kaiserism and not of a nation struggling with democracy.

Another interesting question arises. It is known that labor is migratory, constantly shifting. Also in many large factories the workers live in another state than the one in which they work. For example several hundred thousand wage earners of New York live in New Jersey. Which State should contribute the required 20 per cent? If it be New York, it will scarcely be able to exercise supervisory capacity over the New Jersey Carrier Associations or over the New Jersey doctors, and vice versa. Such working and living conditions exist all over the country.

Compulsory Health Insurance would necessarily set up a physical standard for laborers. Every employer would demand that the worker pass a perfect physical examination. He must do this to protect himself. The number of men who could pass such an examination can be estimated by the number who pass the enlistment examination. Certainly one out of ten would be rejected. Some might find employment but what of the thousands who have some minor physical defect and would be ineligible? Who would care for these workers? Would it be economy to have thousands of idle men and women thrown back on communities, the combined loss of earning power of which would only add millions to the States? One could add to these few reasons many others which tend to show that the arguments of the proponents are not altogether sound. In theory it is a beautiful Utopia; in practice it seems to have disadvantages which grow as more thought is given to the problem.

L. M. W.

AMERICAN DOCTORS.

IN his recent address in Milwaukee Floyd Gibbons, the war correspondent, said that the greatest desire of the wounded ally soldier, be he British, French, Belgian or Italian, is to be sent to an American hospital to receive the care of American surgeons and nurses.

This is a splendid practical compliment to the men and women who have gone across for the humanitarian work of relieving the wounds of war.

And as such, it must bring a patriotic glow to the heart of every American. It is another testimonial—and a most sincere and unaffected one—to the efficiency of America in her war work.

And, at the same time, it should be taken in no sense as a criticism of the medical departments of the other armies of the allied forces.

They, it must be remembered, have borne the brunt of the battle for more than four years. Their force of surgeons has been sadly depleted, and, because the lesson of conserving medical men and nurses had not been learned at the outset of the war, the best trained men in its medical profession were sacrificed and students with all their potentialities for great work were rushed to the firing lines as private soldiers.

The inevitable result of this has been that the allied armies have been short of medical men and their hospital service correspondingly hampered, for a long time. And it is another cause for rejoicing that America was able, by her entry into the war to relieve in a measure this situation.

It is a matter for further gratification that our nation has profited by the experience of her allies and is conserving the medical students, the dental students and other professional men whose services as perfected technicians will be of far greater value than their work as soldiers—splendid as such work must be—and permitting them to complete their education to the end that they may in due course take the places of the efficient exponents of their art who must be sacrificed in service.—*The Milwaukee Sentinel.*

HEALTH INSURANCE.

A CERTAIN doctor, reasonably successful as success is reckoned among doctors, objects to health insurance on the grounds that it will kill private incentive and private initiative. He objects to "the levelling tendencies of socialistic doctrines".

The office of this man is furnished with chairs, a table and window draperies of the generation which followed that of the haircloth "sofy" and coincided with that of the "baseburner". On the reception room table there is a pictorial folder of Niagara Falls, a few copies of "The Literary Digest", the illustrated supplement of a Sunday newspaper and a few other magazines. None of them, however, is by anything but chance less than three months old.

The latest equipment purchased for the consulting room was a rather elaborate and ornate electric wall plate. The test tubes over the wash bowl, with a leaky top, may not have been emptied nor cleaned for days.

The patient looks around and says impertinently, "Say! Whatchemean—'leveling influences'?"

H. D.

MEDICAL MOBILIZATION AND THE WAR

LETTER FROM EDWARD EVANS.

September 10, 1918,
A. R. C. Hospital No. 2.
Somewhere in France.

My dear Editor:

In an idle moment I promised to write you sometime some notes from over here. Not so easy when one tries to arrange impressions or notes in an orderly manner for publication. My impression first and strongest is that over here the R. C. Surgeon is rather an unfortunate bird, in-as-much as while there are numerous R. C. hospitals in the French Army zone, they are manned by M. C. and M. R. C. surgeons and the detached R. C. Surgeon don't as a rule get a "peep in".

Fortunately for me, I was lucky enough at an early date to be sent out to a French "Autochir" during a rush, by R. C. Headquarters and had an interesting experience in seeing a considerable number of gas infections, from mild cases to gas gangrene (G. G.) leading to amputations and not rarely to death.

From this place I moved with the Autochir up back of the line and for ten days we had grave early cases right in from the fighting line and consequently little or no G. G. Most of the wounds are caused by fragments of high explosive shells of all sizes and causing all sorts of wounds, especially you get those fragments buried in any and all parts of the body—often many of them in the same body.

The X-ray man locates them, marks the location, depth, etc., and the surgeon's duty is to extract them ("eclat extract"), together with any foreign body such

as clothing carried in, at the same time carefully and *freely* excising *all* injured or devitalized tissue ("debriedment"). This often, if the fragment is large, entailing very extensive dissection. The wound is then carefully cleansed, ether being very extensively and freely used for this. And the wound is then loosely packed with gauze, or Dakin tubes used; or it is closed either at once or sutures laid in to be tied subsequently, according to the nature and age of the wound and the judgment of the surgeon.

If the fragment has passed through the body, e. g., "seton wound," "debriedment" is done. Bullet wounds rarely call for such radical treatment unless in the flight they encounter bone, when usually the devil is to pay.

Compound fractures are very frequent, and if gotten early, by careful "debriedment" and removal of all loose bone fragments, can be converted into simple fractures by immediate suture *without* drainage.

I had the privilege a few days ago of visiting a fracture hospital where there were nearly 200 cases of fractured femur, most of them thus treated, and after the application of a special apparatus they were gotten out of bed and on crutches, often in ten days or earlier after operation.

Abdominal wounds are apt to be very serious, and are of course seen only very close up to the front. It is astonishing how well the wounded bear the anaesthetic and grave surgical work, considering how they come in from the front, wearied, often exhausted, frequently for quite a long period without sufficient food or drink, and after transportation lasting not infrequently 24 hours and more from place of wounding.

What "gets your goat" more than anything else is the jerky nature of surgical war work. In an evacuation hospital, in shifts of eight or twelve hours on and off, several surgical teams will work at top speed—it may be for several days—then the drive or attack ends in that particular sector. Cases are evacuated as quickly as possible, in preparation for the next drive and this may not come for weeks on end, and everybody perforce loafs; but the "peak load" must be prepared for entailing much idleness and consequent grumbling. Plenty of small mobile units fully equipped seems the best way of meeting these, such as the French Autochir. I have seen one of those pack up a 200 bed hospital, move 45 kilometers, set it up again—including X-ray, sterilizers, operating room, etc.—and functionate between Sunday morning and noon Tuesday.

Our old friend Jack Yates is happy doing reseach work in lung surgery at X. He has with him Doctors Middleton and Drane of the University faculty. Drane still looks like an Indian as the result of mustard gas. Middleton got a reputation as a sprinter in a narrow escape from Hun pursuers. Because of his size he beat them through the wire entanglements, leaving, fortunately, only his uniform on "the wire".

I have seen our American soldiers, only on leave, or when wounded in the hospitals in Paris. We have had very few in the hospitals where I have worked. Everywhere the same story—on leave or in camp—the decentest, cleanest fellow in France; in battle dauntless, wounded—patient, brave and uncomplaining. As upstanding Americans they hate the job but are determined to see it cleaned up very thoroughly and right.

Had I the facile pen of H. M. B., I might do them justice. We're all "hats off" to the American fighter, over here.

Our good friend Lt. Col. Seaman passed within a few miles of us on way to the front two weeks ago with the —— Div. I did not see him. Since this this Division has been doing things to the enemy.

So I might ramble on indefinitely; but these notes are already too long. So cut them down, or cut them out, and believe me,

Cordially yours,

E. Evans.

WAR NOTES

Lieut B. J. Sawicki who has been medical officer at the vocational school at Madison has been transferred to Springfield, Missouri.

Major J. R. Longley of Fond du Lac has arrived safely at Archangel, Russia.

A cablegram has been received from Captain J. R. Eastman of Kenosha, announcing his safe arrival overseas.

Dr. A. S. White of Rice Lake was given a reception at the Commercial Club rooms, October 2, before leaving for service.

Dr. J. H. Francis of Bloomer has sailed for France to engage in Y. M. C. A. work.

Dr. E. J. Kettlehut of Milwaukee has been commissioned a first lieutenant in the U. S. Navy.

Dr. D. L. Dawson of Rice Lake has been ordered to the army medical school at Washington for a three months' course.

Captain S. E. Gavin of Fond du Lac, stationed at Camp Colt, has been promoted to a majority.

A letter from Dr. J. F. Schneider of Oshkosh reports that he is well and enjoying his work over there. He predicts an early termination of the war.

Dr. C. W. Andrew of Waupaca who has been stationed for some time at the Base Hospital Aviation Repair Depot, Dallas, Texas, has been promoted to a majority.

Dr. G. L. Bellis, formerly superintendent of Muirdale Sanatorium, who left for France a year ago to engage in tuberculosis work over there has been promoted from a lieutenancy to a majority.

Dr. Maud R. Williams of Milwaukee has enlisted in the Medical Corps and has been ordered to Camp Grant. She is the only woman physician at the camp.

Captain Eugene Gates of Two Rivers who has been in France for some months has been promoted to a majority.

Captain P. G. Lasche of Milwaukee who is in France writes that he is "having a most wonderful experience, professionally and otherwise."

Dr. G. C. Ruhland, health commissioner of Milwaukee, has been commissioned a major in the Medical Corps.

Word has arrived of the safe arrival over-seas of Dr. George Friedricks of Sheboygan. The doctor is detailed to the 498th aerial squad.

Dr. Henry B. Hitz, Milwaukee Base Hospital 22, has been promoted to a majority. Doctor Hitz sailed in May.

Capt. Arthur J. Patek, Milwaukee, has been ordered to Camp Jackson, S. C., for service in the Base Hospital.

Capt. Otto H. Foerster, Milwaukee, has been ordered to Camp Greenleaf, Chickamauga Park, Chattanooga, Tenn.

Major G. I. Hogue, of Milwaukee, has reached France and is now in active service as a member of the staff of Base Hospital 55.

Capt. Paul Valentine has received orders to report at Fort Riley.

RELATION OF VOLUNTEER MEDICAL SERVICE MEMBERS OF DRAFT BOARDS AND OTHER PHYSICIANS REGISTERED UNDER SELECTIVE SERVICE ACT.

The following is a telegram, dated September 17, from the Provost Marshal-General to *The Journal of the American Medical Association*, published in its issue of September 21:

Membership in Volunteer Medical Service Corps is not service in the military establishment and does not therefore affect in any way the status of registrants before the Selective Service Boards. This statement cannot be made too emphatic. It is unfortunate that any impression has arisen to the contrary.

This matter is of particular importance to medical members of draft boards. Such members of draft boards may not continue to serve thereon after being commissioned in the Medical Corps of the Army or Navy. In view of the enormous labor involved in the physical examination of millions of men in the next few months, the Provost Marshall-General's Office feels very strongly that its needs are vital during the period covered by these examinations, and that it must retain the services of medical members of demonstrated efficiency. It has, therefore, requested the co-operation of the Surgeon-Generals of the Army and Navy and each one of these heads is co-operating by discontinuing for the present the commissioning of medical members of the draft boards in their respective arms of the service. The Surgeon-General of the Public Health Service is co-operating in a similar way. But no question of eligibility to continue to serve as a medical member of the draft boards arises in connection with membership in the Volunteer Medical Service Corps, and resignations of physicians on Selective Service Boards will not be accepted when based on membership in Volunteer Medical Service Corps. Instructions to this effect are going out today to all draft executives. CROWDER.

VOLUNTEER PHYSICIANS FOR UNITED STATES PUBLIC HEALTH SERVICE.

THE JOURNAL has published several announcements asking for volunteers for permanent work as acting assistant surgeons in the Public Health Service. In addition, the Public Health Service is in urgent need of physicians for temporary duty in connection with the influenza epidemic. This work is being organized by states in connection with the state board of health. Physicians who wish to make themselves available for temporary emergency work at a salary of $200 per month and $4 per diem allowance for subsistance should communicate with the Surgeon-General, U. S. P. H. S., indicating their desire to serve, or communicate directly with the Public Health Service officer in their own state.

PHYSICAL QUALIFICATIONS FOR MEDICAL SERVICE WITH THE RED CROSS.

We are informed by Dr. Alfred E. Shipley, secretary of the medical advisory committee of the American Red Cross, Washington, D. C., that every individual going abroad, in whatever capacity, in Red Cross work is required to pass a satisfactory physical examination. In the medical division physicians are sometimes accepted for Red Cross work who, because of physical disqualification, are unable to secure commissions in the Medical Department of the Army. It is appreciated by the Red Cross that such physicians may be used in the medical work among the civilian population abroad as they are not placed under the strain incidental to work in the war areas.

HOSPITALS FOR RECONSTRUCTION.

The Surgeon-General of the Army has taken over Fort Snelling, Minn., Fort Sheridan, Ill., and Fort Benjamin Harrison, Ind., and will convert them into additional general hospitals for the reception of sick and wounded soldiers returned from abroad. They are to be reconstruction hospitals and to fit the wounded for vocational instruction. Each hospital unit will accommodate 1,000 patients.

WOMEN PHYSICIANS WANTED FOR ANESTHETIC SERVICE.

Dr. F. H. McMechan, secretary of the Interstate Anesthetists and the American Anesthetists, Avon Lake, Ohio, states that he is authorized to secure qualified women physicians under 45 years of age an anesthetists for war service. Women physicians desiring to enter this service may communicate directly with Dr. McMechan.

REVISION STANDARDS OF PHYSICAL EXAMINATION.

The office of the Provost Marshal-General has just issued to the draft executives of all states, a revision of Form 75, the Standards of Physical Examination. The changes are few, and are mainly with a view to making available the greater number of registrants having remediable defects (Group B), by transferring them to Group C, for special or limited service. Thus, when inducted and accepted at camps, the defects may be corrected when convenient; meanwhile, the Army will have the benefit of the service of these men.

Registrants who have heretofore, on examination, fallen into Group B (the deferred remediable group) and now, under the revised Form 75, have physical defects placing them in Group C (as physically qualified for special or limited military service), are at once to be reviewed, re-examined if necessary, and recorded in Group C, *subject to call for special or limited military service*.

The next most important change is that which cites certain variations from Army physical standards in the assignment of inducted men to the Navy and the Marine Corps. This states:

5. Navy standards of physical requirements conform in the main to those of the Army included under Group A. But registrants who, on examination, present the following defects, shall not be accepted for service in the Navy or Marine Corps:

Eyes: (A) Vision less than three-quarters of the normal in either eye. (B) Color blindness.

Skin: (A) Parasiting affections, including pediculosis, ringworm and scabies. (B) Eczema. (C) Psoriasis.

Genito-urinary organs and venereal diseases: (A) Absence, atrophy or nondescent of both testicles. (B) Venereal disease, any type or stage.

Height: Over 74 inches.

ARMY TO HAVE SPECIAL REGULATIONS.

Form 75 pertains only to the Selective Service and will not be issued to the Army. In its stead, the Adjutant-General will distribute to all mobilization points a pamphlet known as Special Regulations No. 65, War Department, which is identical with Form 75 as to physical standards.

DESTRUCTION OF PREVIOUS EDITION.

On receipt of the Second Edition of Form 75, old copies of the former edition should be at once destroyed, with the exception of such as are needed to complete permanent reference files.

OFFICERS' UNIFORMS AVAILABLE THROUGH QUARTERMASTER'S DEPARTMENT.

A general order makes the following announcement relative to the supply of officers' uniforms:

III. Section IV, G. O. 56, W. D., 1918, is rescinded and the following is substituted therefore:

1. The following cloths are adopted as standard for officers' uniforms, and all uniforms for officers made in the United States after Dec. 31, 1918, will be one of these prescribed standards:

For coat and breeches, summer wear in the United States and in the tropics only; a, an O. D. cotton; b, a 13-ounce all wool worsted gaberdine. For coats, breeches and overcoats; a, a 12-ounce worsted serge; b, a 16-ounce whipcord; d, a 21-ounce whipcord or elastique; e, a 20-ounce melton. For riding breeches: a, a 23-ounce Bedford cord. For overcoats: a, a 32-ounce melton or kersey.

2. The quartermaster corps will after Dec. 1, 1918, carry a supply of these cloths, and officers can purchase their personal requirements at the government prices. Samples of cloths with the issue prices will be kept on hand by all camp, cantonment and post quartermasters and may be examined by officers on request after the date mentioned. For the present stock will be carried at the following depots only, but this list will be extended from time to time as cloth becomes available: New York depot, Washington depot, Atlanta depot, Sam Houston depot, San Francisco depot, Chicago depot, St. Louis depot.

3. The quartermaster general will determine by thorough investigation a schedule of fair prices for making uniforms, including all necessary trimmings, linings, etc., but not including the cloths, and prepare a list of responsible tailors who agree to make uniforms for officers at the schedule rates, the quartermaster general guaranteeing to the tailors the collection of bills for all uniforms ordered through the representatives of the quartermaster general. The schedule of prices, the list of tailors agreeing to make uniforms at these prices and the regulations governing the sale to officers of the standard cloths, the placing of orders, the acceptance of uniforms ordered and the payment of bills will then be published to the service.

4. The quartermaster corps will arrange to supply from stock at cost made up (ready to wear) officers' uniforms. These will be provided in only two types of cloth for coats and breeches, namely: The 12-ounce worsted serge and the 20-ounce melton and 32-ounce melton for overcoats. It is expected that an adequate supply can be provided at the principal depots mentioned in Paragraph 2 by Nov. 1, 1918, and later at other depots and camps.

ORDERS TO OFFICERS OF THE MEDICAL CORPS, U. S. ARMY.

To Camp Crane, Pa., from Camp Grant, Capt. H. M. Kay, Madison; Lieut. J. T. Klein, Columbus; from Camp Meade, Lieut. A. A. Charbonneau, Green Bay.

To Camp Custer, Mich., base hospital, from Camp Grant, Lieut. W. F. Grotjan, Milwaukee.

To Camp Grant, Ill., from Fort Oglethorpe, Lieut. L. E. Youmans, Mukwonago.

To Camp Lee, Va., from Fort Oglethorpe, Capt. W. D. Harvie, Oshkosh.

To Camp Logan, Texas, from Fort Riley, Lieuts. J. M. Baasen, Mount Calvary; E. L. Schroeder, Shawano.

To Denver, Colo., from New Haven, Lieut. L. F. Ruschhaupt, Milwaukee.

To Fort Benjamin Harrison, base hospital, from Camp Travis, Lieut. F. J. Korthals, Milwaukee.

To Fort Riley for instruction, Lieut. P. G. McCabe, Dotyville.

To Army Medical School for instruction, from Routoul, Ill., Lieut. D. L. Dawson, Rice Lake.

To Camp Abraham Enstis, Va., camp hospital, and on completion to Boston, Mass., Harvard Graduate School of Medicine, for instruction, from Fort Oglethorpe, Capt, J. W. Powers, Burlington.

To Camp Cnster, Mich., from Fort Oglethorpe, Lieut. S. J. Seeger, Milwaukee. Base hospital, from Camp Sherman. Capt. F. E. Andre, Kenosha. Base hospital, for instruction, Lieuts. R. E. Flynn, La Crosse; H. McCabe, Milwaukee.

To Camp Gordon, Ga., base hospital, from Camp Gordon, Lieut. J. W. Hansen, Milwaukee.

To Camp Grant, Ill., from Army Medical School, Lieut. C. A. Cibelius, Racine.

To Camp Jackson, S. C., base hospital, Capt. S. G. Pake, Hayward.

To Camp Sherman, Ohio, as sanitary inspector, from Camp Zachary Taylor, Major W. W. Pretts, Platteville. To examine the command for nervous and mental diseases from Camp Grant, Capt. J. F. Wenu, Milwaukee.

To Camp Travis, Texas, from Fort Riley, Capt. F. W. McKee, Richland Center; Lieut. S. C. McCorkle, Wallis.

To Fort Benjamin Harrison, base hospital, from Camp Custer, Lieut. V. Starnes, Mauston; from Camp Grant, Lieut. J. B. Vedder, Marshfield.

To Fort Riley for instruction, Capt. A. J. Gates, Tigerton; Lieut H. J. Gramling, Milwaukee.

Honorably discharged on account of physical disability existing prior to entrance into the service, Lieut. G. F. Kenney, Milwaukee.

To Camp Gordon, Ga., base hospital, from Army medical School, Capt. F. A. McJunkin, Milwaukee.

To Camp Grant, Ill., base hospital, for instruction, Lieut. J. M. Arnson, Eau Claire.

To Camp McClellan, Ala., to examine the troops for cardiovascular diseases, from Fort Oglethorpe, Lieut. E. I. Moquin, Fairwater.

To Camp Sevier, S. C., base hospital, for instruction, from Fort Oglethorpe, Capt. H. A. Robinson, Kenosha.

To Fort Leavensworth, Kan., Lieut. F. C. Christensen, Racine.

To New York, Bellevue Hospital, for instruction, from Fort Oglethorpe, Lieut. W. G. Darling, Milwaukee.

To Camp Hancock, Ga., base hospital, from Fort Oglethorpe, Capt. W. S. Darling, Milwaukee; Lieut. C. W. Lockhart, Mellen.

To Fort Oglethorpe, evacuation hospital, from Camp Joseph E. Johnston, Capt. V. F. Marshall, Appleton.

To Rahway, N. J., from Boston, Lieut. H. E. Bundy, Milwaukee.

To Rochester, Minn., Mayo Clinic, for instrnction, and on completion to Fort Des Moines, Iowa, for instruction, from Fort Riley, Lieut. J. M. Ross, Bloom City.

To Camp Cody, N. M., base hospital, from Fort Bayard, Capt. L. J. Bennett, Fort Atkinson.

To Camp Crane, Pa., from Camp Joseph E. Johnston, Capt. G. E. Thompson, Kenosha. Base Hospital, from Camp Custer, Capt. J. G. Taylor, Milwaukee.

To Camp Gordon, Ga., base hospital, from Fort Oglethorpe, Capt. O. H. Foerster, Milwaukee.

To Camp Grant, Ill., evacnation hospital, from Camp Custer, Lieut. H. McCabe, Milwaukee.

To Camp McClellan, Ala., from Fort Riley, Lieut. P. M. Ross, Milwaukee. Base hospital, from Fort Oglethorpe, Capt. N. Andrews, Oshkosh.

To Camp Meade, Md., base hospital, from Fort Oglethorpe, Lieut. F. M. Rohow, Ashland.

To Camp Wadsworth, S. C., base hospital, from Fort Oglethorpe, Capt. A. O. Sanders, Superior.

To Fort Benjamin Harrison, base hospital, from Camp Pike, Capt. E. F. Baur, Milwaukee.

To Fort Oglethorpe, evacuation hospital, from Camp Zachary Taylor, Capt. C. U. Senn, Ripon.

To Mineola, N. Y., Hazelhurst Field, for instruction, from Dallas, Capt. C. W. Andrews, Waupaca.

To Pittsburgh, Pa., Carnegie Institute, and University of Pittsburgh, from Camp Meade, Capt. H. A. Rice, Gays Mills.

To San Antonio, Texas, Brooks Field, from San Diego, Capt. F. W. Pope, Racine.

To Washington, D. C., Surgeon-General's Office, for instruction, from Fort Riley, Capt. T. L. Harrington, Milwaukee.

COMMISSIONS OFFERED AND ORDERS TO DUTY ON ACCEPTANCE.

To Camp Jackson, S. C., base hospital, Capt. A. J. Patek, Milwaukee.

To Camp Meade, Md., Lieut. V. G. Foley, Wauwatosa.

To Camp Pike, Ark., for instruction, Lieut. A. Yaffe, Milwaukee.

To Fort Oglethorpe for instruction, Capts. W. A. Prouty, Burlington; C. A. Fidler, Milwaukee; R. W. Jones, Wausau; Lieuts. E. S. McNevius, Green Bay; J. J. Heffron, Milwaukee.

To Fort Riley, Capt. L. W. Sayles, Baraboo. For instruction, Lieuts. G. E. Bilstad, Cambridge; A. M. Christofferson, Colby; J. E. Dounell, Cuba City; F. P. Marshall, Fond du Lac; F. L. Crikelair, Green Bay; S. W. Murphy, Kenosha; H. E. Schmidt, Milwaukee; C. M. Schuldt, Platteville; J. A. Cox, Wautoma.

To Mineola, N. Y., Hazelhurst Field, for instruction, Lieut. V. L. Simones, La Crosse.

To Camp Dodge, Ia., base hospital, for instrnction, Lieut. E. E. Dale, Lusk.

To Camp Meade, Md., Lieut. W. S. Puncheon, Rock Springs.

To Fort Oglethorpe for instruction, Capt. O. H. Foerster, Milwaukee; Lieuts. F. L. Griswold, Mazomaine; J. H. Carroll, Milwaukee; W. C. Comee, Seymour.

To Fort Riley for instruction, Capt. M. A. Dailey, Fennimore; Lieuts. J. M. Ross, Bloom City; F. H. Baldwin, Bloomington; W. J. Waldschmidt, Fond du Lac; R. R. Rath, Granton; R. C. Godfrey, Lancaster; R. C. Westhofen, Milwaukee; G. A. Natvig, Prairie Farm; G. W. Curless, Walworth.

To Camp Custer, Mich., base hospital, for instruction, Lieuts. H. F. Derge, Eau Claire; L. E. Beringer, Plymouth; F. Nee, Spring Green.

To Camp Dodge, Iowa, base hospital, for instruction, Capt. G. J. Egan, La Crosse.

To Camp Grant, Ill., for instruction, Lieut. J. A. Heraty, Milwaukee.

To Camp Pike, Ark., base hospital, for instruction, Capt. C. O. Latham, Green Bay.

To Fort Oglethorpe for instruction, Capt. E. D. Rigby, Milwaukee; Lieuts. F. B. Welch, Janesville; B. F. Koch, Wauwatosa.

To Fort Riley for instruction, Lieuts. C. W. Rice, Delavan; H. J. Haubrick, Oshkosh; R. E. Doern, Stockbridge.

To New Haven, Conn., Yale Army Laboratory School for instruction, Capt. J. J. Seelman, Milwaukee.

To Fort Oglethorpe for instruction, Capt. I. G. Thompson, Eau Claire.

To Fort Riley for instruction, Capt. L. P. A. Valentine, Milwaukee; Lieuts. R. Cahoon, Baraboo; A. J. Wiesender, Berlin; C. E. Myers, Milladore; R. F. Braun, P. J. Merten, Milwaukee; J. M. Conway, Spring Valley.

To New Haven, Conn., Yale Army Laboratory School, for instruction, Lieut. L. R. Fowser, Manawa.

To Camp Custer, Mich., Lieut. W. L. Herner, Milwaukee.

To Camp Dodge, Iowa, base hospital, for instruction, Lieut. R. M. Carter, Green Bay.

To Fort Oglethorpe for instruction, Lieut. D. B. Dishmaker, Kewaunee.

To Fort Riley for instruction, Lieuts. A. D. Andrus, Ashland; A. M. Rosenheimer, Fox Lake; L. J. Simon, Horicon; G. W. Reis, Junction City; C. L. McCollum, Manitowoc; S. Bergland, Marinette; J. J. Eisenberg, L. J. Foley, G. T. Savage, Milwaukee; E. C. Cary, Reedsville.

To New Haven, Conn., Capt. R. L. Williams, Statesan.

A MESSAGE FROM BELGIUM.

Captain Dr. Rene Sand of the Belgium Ministry of Reconstruction was asked, during a recent visit to America: "How may America best pay her share of the debt of gratitude which the whole civilized world owes to that heroic and undaunted little country? What can we best do to help Belgium after the war?" In his reply, which appears in the current issue of *The Modern Hospital,* Captain Sand says that the first few months of peace will decide the fate of Belgium. Material help, personal help and advice will be especially needed in meeting the social problems—infant mortality, bad housing, occupational hazards, tuberculosis, alcoholism, venereal disease —which, in their most acute forms, must be solved.

Here, Captain Sand aptly suggests, is America's golden opportunity to assist this indomitable little nation to establish itself on a higher plane than ever before. According to Captain Sand, a permanent American foundation in Belgium, to foster research, to offer information on reconstruction problems, and to maintain an educational campaign for raising the standards of life in Belgium, would be the ideal means of serving his country and strengthening the bonds of friendship between Belgium and America.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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TERM EXPIRES 1919

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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES.

County.	President.	Secretary.
Ashland-Bayfield-Iron	M. S. Hosmer, Ashland	C. J. Smiles, Ashland.
Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
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Calumet	W. C. Schmitz, School Hill	F. P. Knauf, Kiel.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillisville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	L. H. Prince, Madison	W. H. Sheldon, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	H. E. Twohig, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	R. E. Flynn, La Crosse	Jens Rosholt, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Schockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	J. E. Meany, Manitowoc.
Marathon	W. E. Zilisch, Wausau	F. H. Frey, Wausau.
Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. H. Fellman, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	A. R. Bell, Tomah	S. D. Beebe, Sparta.
Oconto	C. W. Stoelting, Oconto	Minnie Hopkins, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	F. R. Boyer, Rhinelander.
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Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
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Portage	D. N. Alcorn, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	G. C. Wichman, Rib Lake.
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Waukesha	G. E. Peterson, Waukesha	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	J. W. Lockhart, Oshkosh	F. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Ruckle, Grand Rapids.

SOCIETY PROCEEDINGS

DODGE COUNTY

A meeting of the Dodge County Medical Society was held at Minnesota Junction September 24th at 12 o'clock noon and followed a dinner at the local hotel. Dr. Thaddeus Smith of Neenah addressed the society on his experiences in France during the present war.

A. E. Bachhuber, M. D., *Secretary.*

GRANT COUNTY MEDICAL SOCIETY

A meeting of the Grant County Medical Society was held at Boscobel Thursday, Sept. 1. The attendance at these meetings is necessarily smaller than formerly, as so many of our members are in active service at the front. But there was enthusiasm, for each one was endeavoring to learn how he could best serve the country and community in which he lives. Dr. L. H. Hayman of Pasadena, Cal., formerly of Boscobel, who retains his membership in this society, was present. Reports of interesting cases and discussions of subjects of interest to the medical profession relating to the war formed the program for the day.

MILWAUKEE MEDICAL SOCIETY

A special meeting of the Society was held on Friday evening, October 18th, at 8:30 o'clock, at the Hotel Wisconsin. Lieutenant F. I. Ridge of the U. S. Navy, who has had extensive experience in the study of the recent epidemic of Influenza, with other medical officers of the Great Lakes Naval Training Station, addressed the Society on "The Bacteriology, Pathology, Epidemiology and Treatment of Cases of the Recent Epidemic Occurring at Great Lakes."

Daniel Hopkinson, M. D., *Secretary.*

NINTH COUNCILOR DISTRICT.

The Autumn meeting of the Ninth Councilor District Medical Society was held in Wausau September 27th, 1918. A clinical meeting and demonstration of cases was held at St. Mary's Hospital. At seven o'clock a dinner was served at the Wausau Club followed by a symposium on "Medical Features of the Selective Service Act." Discussion was opened by Dr. A. W. Trevitt for Local Boards and Karl Doege for Medical Advisory Boards. Dr. W. A. Green discussed the Volunteer Medical Service Corps. A general discussion followed.

Jos. Smith, *Secretary.*

PRICE-TAYLOR COUNTY

A meeting of the Price-Taylor County Medical Society was held August 29th. Dr. G. H. McClure of Westboro was appointed president to fill the vacancy caused by the absence of Dr. Riley who has entered the service. Dr. W. P. Sperry was appointed delegate to the state meeting.

G. C. Wichman, M. D., *Secretary.*

WISCONSIN WOMEN'S MEDICAL SOCIETY.

The Wisconsin Women's Medical Society met at an informal dinner at the City Club, Milwaukee, October 2, 1918, at 5:30 P. M.

Dr. Bertha Van Hoosen of Chicago spoke on the uses of emetin intravenously in carcinoma. She also made a plea for six women physicians for immediate over-seas service, with the American Women's Hospitals and asked all those desiring further information to communicate with her.

The society resolved that a letter be sent to every woman physician in this state, urging immediate registration in the Volunteer Medical Service Corps.

All officers were re-elected, namely: President, Irene Tomkiewicz Stemper, Oconomowoc; Vice-president, Ada B. Chandler, Pardeeville; Secretary and Treasurer, Belle P. Nair, Winnebago.

He who has been given of the magnetic stone is with great difficulty cured (of its poison) for it maketh him lunatic or melancholic or delirious, and his cure is that he be given the extract of gold and of fragments of emerald up to the amount of one-half a drachm each, with wine; and he should be clystered with ewes milk and oil of sweet almonds, and the antidote (bezoar) of it is: powdered emeralds and given in a drink three times in nine days.

—Petrus d' Apono, De Venena.

ASSOCIATION NEWS

INFLUENZA SYMPOSIUM AT A. P. H. A. MEETING.

The influenza epidemic will be made the most important subject of discussion at the December meeting of the American Public Health Association. Some of the questions which will be discussed are the following:

Is influenza vaccine efficacious as a prophylactic?

What type of vaccine is most useful?

Does it help as a therapeutic?

What about nose and throat sprays?

What are the results with convalescent serum?

What about the open-air treatment?

How can the health officer co-ordinate hospital, medical, health, and relief agencies in similar calamities?

How can we take advantage of the epidemic for the benefit of more adequate health appropriations and better community and personal hygiene?

The detailed influenza program is not yet ready as we go to press. The rest of the program will be substantially the same as previously announced. The papers read at the meeting will be published in the American Journal of Public Health.

Headquarters of the meetings will be at Hotel Morrison, Chicago; the dates, December 9-12, 1918.

The secretary of the Association may be addressed at 126 Massachusetts Avenue, Boston, Mass.

OUR NEW PRESIDENT.

D. J. HAYES, M. D.

Doctor Hayes was born in Richfield, Wisconsin, in 1854 and, after completing the courses usually pursued in preparation for the study of medicine at that time, he entered Northwestern University Medical School, Chicago, from which he graduated in 1879. He immediately located at St. Nazianz, Wisconsin, where he conducted an extensive country practice from 1879 to 1887. In 1887 Doctor Hayes entered upon a year's post graduate course in Vienna, Austria, devoting particular attention to Genito-Urinary Surgery. Immediately upon his return from Europe he located in Milwaukee where he has practised continuously ever since. Dr. Hayes was one of the founders of The Wisconsin College of Physicians & Surgeons and held the chair of Genito-Urinary Surgery and Clinical Surgery from 1893 to 1907. In addition to his activity in promoting medical education in Wisconsin, Doctor Hayes was professor of Genito-Urinary Surgery in the Post Graduate Medical School of Chicago from 1891 to 1897. The new president is a fellow of the American College of Surgeons, the American Urological Assn., the American Medical Association and the several local medical and surgical societies.

INFLUENZA POSTPONES CONVENTION OF AMERICAN PUBLIC HEALTH ASSOCIATION.

The influenza epidemic caused the postponement to December 9-12 of the annual meeting of the American Public Health Association, which was to have been held October 14-17. A good attendance was assured from the upper Mississippi Valley where influenza had not yet become generally epidemic. However at the urgent request of the Surgeon General of the U. S. Public Health Service and of many Eastern speakers and delegates, the later date was set, it being judged unwise to take sanitarians from their posts at this time.

Further announcement will be issued by the Association at Boston, and will be published in the American Journal of Public Health.

NEWS ITEMS AND PERSONALS.

The new Madison Tuberculosis Sanatorium was formally presented to the Madison Anti-Tuberculosis Association, October 8, by Dr. Charles H. Vilas as a memorial to his mother, Esther Smilee Vilas. The institution is situated in the town of Blooming Grove and overlooks Lake Wobesa. It is about five miles from Madison, and was begun about a year ago by the association on the land donated by Dr. Vilas who later took over the five buildings and completed them at his expense. The institution is to be held in trust and conducted without profit. Although primarily for Dane County patients, others will be accepted from out in the state. Dr. L. R. Head is director of the new hospital. The trustees are Dr. L. R. Head, Dr. T. W. Tormey, Dr. W. D. Frost, Mrs. A. F. Dexter, W. H. Heddles, L. W. Hutchcroft, R. R. Kropf, Dr. L. H. Prince, and Miss Amy Daniels.

Doctors Charles Reineck and E. W. Cooney of Appleton have been appointed physicians in charge of the medical and surgical work of the S. A. T. C. at Lawrence College.

The county board of Racine county has voted to accept and maintain a one-hundred bed hospital which is to be constructed through private subscriptions and a $25,000 appropriation from the Racine county war chest. The hospital will be for the care of wives and other relatives of the soldiers and sailors in the service as well as for the wounded boys when they return from the front. The county assumes the management and will pay the maintenance expenses.

Health-officer B. L. Schuster of Wausau called a meeting of all the physicians of the city, October fourth, at the co-operative laboratory rooms for the purpose of discussing the epidemic of influenza.

Dr. P. G. McGill, health commissioner of Superior, has addressed a letter to the mayor and city council urging the erection of an isolation hospital.

The shortage of physicians in the state, due to war conditions and the increased amount of work caused by the epidemic of influenza, seriously interfered last month with the physical examination of registrants by many local Boards. Several Wisconsin physicians patriotically came to the front and helped out in the emergency. Dr. J. J. Curtin of Sturgeon Bay went to Kenosha and with the help of internes from Chicago finished the work for one of the Kenosha boards. Dr. John B. Sherbon of Cumberland and Drs. Dodd and Shaw of Ashland did the work for the local board at Philipps. Ten Milwaukee physicians went to Pt. Washington on Sunday, October 20, and finished the work for the Ozaukee county board.

The absurd rumors circulated, no doubt, as pro-German propaganda, to the effect that physicians at Camp Grant, Great Lakes and other cantonments had inoculated soldiers and sailors with influenza and pneumonia, has been branded as false and libelous by the war department at Washington.

The large Kissel home at Hartford, Wisconsin, will be converted into a hospital to be in charge of Miss Helen Lohr and Miss Grace King, both graduates of the Milwaukee nurses' training school.

Dr. W. A. Hazelton of Baraboo has located at Hayward.

At a meeting of the finance and judiciary committee of the Milwaukee county board, October 25, $30,000 was included in the 1919 budget for the purpose of creating a general clinic and public dispensary in Milwaukee. Doctors Ruhland, Cohn, Dearholt, Dewey, Christianson, and Reverend W. H. Grenman appeared before the board in favor of the adoption of such a budget.

Dr. Arthur Niemann of New Holstein, in response to an appear for medical help from Blue River, went there and took over the work of the only physician there who was ill with pneumonia.

The industrial commission announced the adoption of amendments to its rules of practice in the administration of the compensation act with reference to the reports required from insurance companies and self-insured employers. One amendment requires such insurance companies and employers to file with the final report in each compensation case in which there is any permanent disability, a copy of a report from a reputable physician showing the extent of disability. Another amendment requires a physician's report in all cases in which stipulations of facts are submitted by the parties to the commission to enter an award thereupon.

Ninety-five per cent of all compensation cases in Wisconsin are settled automatically between the parties without requiring any formal hearings on the part of the industrial commission. The commission, however, checks all settlements made in these cases to make certain that payments of compensation are made in accordance with law. It has been found difficult in many cases to determine whether this is being done because the exact extent of the injury was not clearly stated.

It is for this reason that the commission has adopted amendments to its rules of practice requiring the filing of doctors' reports in all cases in which there is any permanent partial disability. These doctors' reports may be presented in any form, but should state clearly the extent of the permanent disability.

William Black, 60 years old, who for many years while in Milwaukee claimed he was a physician, was taken into custody by Paul G. Dorsch, special investigator for District Attorney Zabel. He was booked in county jail on two charges, "practicing medicine without a license and attempting to perform an illegal operation." Black came to Milwaukee from Indiana several years ago. He was arrested in his room in the Gilpatrick hotel, where physician's instruments were found by Mr. Dorsch.

Dr. C. A. Harper, state health officer, has been made Wisconsin representative of the federal public health service. Burt Williams, collector of internal revenue for the western Wisconsin district, has been appointed Wisconsin representative of the American Red Cross for work in connection with the influenza epidemic.

Mrs. E. Federman of Montello is in Milwaukee where she has taken a position with the health department. Her husband, Dr. Federman enlisted at Montello recently and is in the army.

Walter B. Swift, A. B., S. B., M. D., of Boston, has just been appointed Consultation Expert for Speech Defects to the Division of Medical Inspection of the Public Schools of Cleveland, Ohio. He is engaged in installing methods in speech correction by directing some 15 teachers to conduct speech correction classes. These teachers he trained up last summer to do this work.

DEATHS

Dr. James Clyde Stormont, Viola, died October sixth of influenza after an illness of four days. Doctor Stormont was thirty-five years of age, a graduate of the Milwaukee Medical College, class of 1903. In a two column appreciation in the Viola News, we find, "He cheerfully sacrificed himself giving aid to others in his stricken community while he himself suffered under a relapse which hastened into pneumonia." His death occurred on the very day he received his commission as first lieutenant in the Medical Corps of the army. He was a member of the Vernon County, State of Wisconsin, and A. M. A. medical associations.

Dr. Ray Howard Rice, Delavan, died October 2, 1918, at the age of forty-four. He was a graduate of Bennett Medical College, Chicago, class of 1898. He practiced one year at Jefferson, Wisconsin, and then removed to Delavan in 1899. His death was caused by pneumonia. He was a member of the Walworth County, Wisconsin State, and A. M. A. Medical Societies.

Dr. Edward R. De Both, Green Bay, died of influenza on Sunday, October sixth. He was thirty-two years of age, a graduate of Rush Medical College, class of 1911. During his college years at Beloit and the University of Chicago, he was considered one of the leading athletes in the west and played half-back on the University of Chicago team. Dr. De Both, who was public health officer and marine physician, contracted influenza while attending Great Lakes jackies taken ill while the band was in Green Bay in the interests of the Fourth Liberty Loan. Dr. De Both had accepted a commission in the Medical Corps but had not been called to active service. He was a member of the Brown-Kewaunee County, Wisconsin State, and A. M. A. Medical Associations.

Dr. George Grey, Baltimore, Maryland, a former Milwaukee physician, died of pneumonia, following an attack of influenza October twelfth. He was a graduate of the University of Wisconsin in 1907 and of John Hopkins Medical School in 1911. He was later transferred to Boston where he acted as assistant to Dr. Cushing. During the past month, Dr. Grey had been appointed as chairman of the new Rockefeller Institute established in Peking, China. The post was to have been filled by him after the termination of the war.

Dr. Ottmar Schallern, Ripon, died at St. Agnes Hospital, Fond du Lac, where he had been for treatment since July, on October twentieth. He was seventy-four years of age and had practiced his profession at Ripon for the past thirty years. Dr. Schallern leaves a brother, Dr. Bruno Schallern, who is practicing in Ripon at this time. He was a former member of the Fond du Lac County, Wisconsin State and A. M. A. Medical Associations.

Dr. William D. Krebs, Green Bay, died at his home in Green Bay, October eighteenth. Doctor Krebs was born in Ft. Atkinson, March 23, 1887, and graduated in medicine at Marquette University in 1914. He had practiced at Cecil before locating in Green Bay. He was a member of the Shawano County, Wisconsin State and A. M. A. medical associations.

Dr. Clyde S. Horton, Edgerton, died October sixth, of pneumonia following influenza. Doctor Horton was born in 1879 and graduated from the medical department, University of Illinois, 1907. He practiced at Barnevald before removing to Edgerton. The Edgerton Reporter states "Without question, he surrendered his life through his devotion to his profession. When the present epidemic came upon us and calls from patients multiplied, he worked night and day to relieve the suffering of others beyond his endurance."

Dr. Lawrence D. Gillick, Pulaski, died after a few hours illness of influenza on October sixteenth. He graduated from Marquette University in 1905 and made a reputation as a foot-ball star while there. He graduated from the Marion Sims medical school, St. Louis, four years later. He had practiced in Pulaski for eight years and was thirty-two years of age.

Dr. J. F. Doyle, Santa Anna, California, a former Antigo physician, died at his home October ninth. Doctor Doyle was one of the pioneer physicians of Langlade county. He removed to California twelve years ago.

Mrs. Frank E. Brown, wife of Dr. F. E. Brown, 2904 Wells Street, Milwaukee, died October fourteenth from injuries received in a street car accident. She was born in Lancaster, Wisconsin, and the body was taken there for burial.

Mrs. A. J. Randall, wife of Captain A. J. Randall, Kenosha, died at Kingston, Ontario, October seventeenth, of influenza. Captain Randall left Kingston a month ago for over-seas service and at that time his wife was in splendid health.

MARRIAGES

Lieutenant Stanley Seeger, Milwaukee, to Miss Helen Brachman, Texarkana, Texas, early in October.

Dr. Henry A. Peters of Oconomowoc to Miss Emma Nicholas of Ft. Atkinson, September eighteenth.

Dr. G. F. Kelly, Milwaukee, to Miss Eulalia M. J. Leahy of Monroe, October ninth.

An adjustable abduction arm splint made in the American Red Cross splint shop at Villa St. Michel, France. This splint is articulated at the joints in order to bring the arm at right angles with the body. It can be used at any height according to the treatment required by the fracture, or used as a Thomas arm splint adopted by the U. S. Medical Corps.

There is also about the Nile great store of Skinks which are like Crocodiles, but of lesser making and shorter, howbeit they are very necessarye for the preservation of helth. For physicians make drinks of them to ease the numness of sinewes, and kil the force of payson.

—Caius Julius Solinus.

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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INFLUENZA.

During the spring of this year there appeared in Spain an epidemic of an acute respiratory infection diagnosed influenza. Since them many other countries have been suffering from the same infection. This infection spreads very rapidly, and soon affects most of the susceptible population in the community.

Influenza uncomplicated is not a dangerous disease. It is the secondary pneumonias which have been so fatal, 60% to 70%.

Everywhere in this country very strict measures have been enforced to prevent people from gathering in crowds. It is well known that it is a crowd disease. That is to say, that it is easily passed from one person to another and when people come in close contact in large numbers as in theatres, churches, etc., there is almost certain to follow a number of new cases infected from people who have only a mild case or who have recovered, and are still carrying the organism. The enforced quarantine upon public places where people congregate has undoubtedly been very effective as a barrier to the spread of the infection. People have come to realize more than ever the danger they may be to their neighbors and friends. The infectiousness of secretions expelled from the nose, mouth, and throat while talking, and especially when sneezing and coughing, has not only become widely known, but the knowledge which most people had before has been put into practice, so that you seldom see now one who will cough or sneeze without covering his mouth and nose.

This epidemic should do a great deal to enlighten people upon the origin or source of infectious diseases. It should do much to dispell the motion that environment has a great deal to do with epidemic diseases, and pretty firmly establish in the minds of people that disease is spread largely through direct contact with those who are actually sick or with carriers.

There is some doubt concerning the cause of epidemic influenza. In 1892 Pfeiffer described a small bacillus, which has since gone under the name of influenza bacillus, and has quite generally

been accepted as the cause of this disease. There appears to be good reason to doubt this. Streptococci, pneumococci and other bacteria occur as frequently in the respiratory tract of these cases as does the influenza bacillus, and there appears to be just as good reason to believe that influenza may be caused by the pneumococcus as by the so-called influenza bacillus. Bacteriological studies during the present epidemic should do much to clear up this subject. It may be possible to bring out facts during this epidemic which will show conclusively the relation of Pfeiffer's bacillus to epidemic influenza.

Prevention is the subject of greatest concern now. Everybody wants a vaccine. That, of course, is our aim, to secure a prevention, and if not a prevention a certain cure. While speaking of preventive agents, vaccines, it gives me an opportunity to say that for a number of years the State Laboratory has been distributing free of charge a vaccine which has been proven to have preventive qualities against typhoid fever. The population of the State is something over 2,000,000. Last year we sent out only 5,000 doses of antityphoid vaccine, and at the same time there occurred about 1,330 cases of typhoid fever and 133 deaths from that disease.

We know very little concerning the value of the influenza vaccines. As to whether they will prevent influenza is to be proven. In Chicago a vaccine is being tried out. Dr. Rosenow has prepared a vaccine which he has reason to believe has value as a prevention and is using it in this epidemic. In Massachusetts a vaccine is being used. Committees have been appointed to study the results obtained from the use of these vaccines.

In the Journal of the American Medical Association for October 19th, on page 1317, is published the statement of two of these committees.

One committee, Drs. M. J. Rosenau, Frederick P. Gay and George W. McCoy are the authority for the following statements:

"1. The evidence at hand affords no trustworthy basis for regarding prophylactic vaccination against influenza as of value in preventing the spread of the disease, or of reducing its severity. The evidence from the present epidemic, though meager, suggests that the incidence of the disease among the vaccinated is smaller than among the non-vaccinated. The board, therefore, concludes that further experimental evidence should be collected.

2. The evidence at hand convinces the board that the vaccines we have considered have no specific value in the treatment of influenza.

3. There is evidence that no unfavorable results have followed the use of the vaccines."

Dr. George C. Whipple, William H. David, and F. C. Crum reported as follows:

"1. The weight of such statistical evidence as we have been able to accumulate indicates that the use of the influenza vaccine which we have investigated is without therapeutic benefit. Exceptional cases where apparent benefit has resulted from the use of the vaccine can be matched by other cases where similar recoveries have been made without vaccination.

2. The statistical evidence, as far as it goes, indicates a probability that the use of this influenza vaccine has some prophylactic value.

3. There is also some evidence to the effect that other methods of protection, such as open-air treatment and the use of proper masks, are effective in protecting exposed attendants, and the use of vaccine should not be taken as an excuse for omitting such safeguards."

As a result, the following recommendations were made:

"That the state encourage the distribution of influenza vaccine intended for prophylactic use, but in such manner as will secure scientific evidence of the possible value of the agent.

That the state shall neither furnish nor endorse any vaccine at present in use for the treatment of influenza."

The State Laboratory of Hygiene is preparing a vaccine, which will soon be ready for distribution.

HOW MILWAUKEE ORGANIZED ITS FIGHT AGAINST THE "FLU."

Prompt action, an intensive publicity campaign unparalleled in the history of the city, and the responsiveness and co-operation of the public, both as official and unofficial organizations and as individuals, are held by Dr. George C. Ruhland, health commissioner of the city of Milwaukee, to be the three great factors which have enabled Milwaukee to break the first force of its epidemic of influenza within a month of its outbreak.

On Sept. 15 two Jackies from the Great Lakes Naval Training Station were taken ill in Milwau-

kee. Dr. John T. Koehler, deputy health commissioner of Milwaukee was called to attend them, and thus the city health department got its first warning. A telegram canvas of the physicians gave a total of 98 cases that might be characterized as influenza, grippe, or hard colds for the entire preceding week, a low record for a city the size of Milwaukee. Dr. Ruhland, however, asked all physicians to report all new cases promptly and also requested Capt. Moffett, the commandant at Great Lakes, to keep the Jackies away from Milwaukee until all danger of an epidemic should be over.

Six cases of influenza were reported to the city health department Sept. 26, 24 on Sept. 27, 62 on Sept. 28 and 97 on Sept. 30. Then the number fell for a few days. On Oct. 2, four deaths were reported and the next day there were four more.

On Monday, Oct 7, 256 new cases and 9 deaths were reported and on that afternoon the health commissioner went before the city council, outlined the gravity of the situation, and asked for an appropriation for fighting the epidemic. Hospital facilities, overtaxed in normal times, were totally inadequate to meet the emergency and additional hospital room for the isolation and care of patients were absolutely necessary.

Milwaukee responded. The council, unable to appropriate the money legally at that meeting, called another one for the next day and voted $15,000. The county board of supervisors on the same afternoon voted an additional $15,000, recognizing that combined action by city and county was essential to success in the fight.

On the following day the Nunnemacher residence on Grand avenue was secured as an emergency hospital and the services of the Citizens' Bureau of Municipal Efficiency enlisted. H. L. Henderson, director of the bureau, took personal charge of securing the equipment for this hospital, the city purchasing board and other departments co-operating by looking after various details of the work. Early Wednesday afternoon the first patient was received in the hospital, the building having been thoroughly cleaned and new furniture moved in in the meantime. The next Saturday night Dr. Koehler telephoned Mr. Henderson that the monster Auditorium had been secured as a second emergency hospital and on the following Monday it began receiving patients.

In the meantime other important phases of the campaign were being organized and put into immediate execution. Newspaper editors were called into conference, told of the experience in eastern cities pointing to at least 160,000 cases in Milwaukee unless necessary precautions to check the epidemic were taken early, and their co-operation in an aggressive campaign to arouse the public without unduly frightening it by scareheads and and sensationalism was urged. This co-operation was readily pledged and given.

Early in the organization of the campaign, Dr. Ruhland appointed an advisory committee consisting of Col. Otto H. Falk, Carl Herzfeld, Dr. Louis F. Jermain, and Dr. Hoyt E. Dearholt, this committee acting with him in the laying out of the entire campaign.

Every appeal for help found immediate response. Among the organizations which put its resources entirely at the disposal of the city health department was the Wisconsin Anti-Tuberculosis association. Students in the associations training classes for public health nurses and for health instructors went in as volunteers to assist with the regular field work of the health department nurses, thus relieving them for work in the hospitals. Dr. E. V. Brumbaugh, director of the training course for health instructors, took charge of the work of organizing a large army of volunteers including the public school teachers who made a survey of the city to discover unreported cases. He, Dr. Dearholt, and several members of the health instructors' class gave noontime talks at various factories and similar talks were also given by the four minute men of the County Council of Defense, which took charge of this line of the work.

Since the schools have been closed, the public school nurses have been aiding the health department forces in two hospitals one of which is under the direct personal charge of Dr. Lobedan of the child welfare department and the other under Dr. Ford. In both hospitals a large force of volunteer Red Cross Nurses' Aides has been on duty night and day, giving service that has called forth the hearty praise and admiration of the professional nurses. These volunteer aides work in three eight hour shifts. Ten Jackies from Great Lakes have been assigned to duty in Milwaukee and work as male nurses. Volunteers from the medical Corps of the Wisconsin State Guard serve as orderlies.

Valiant service is also given by the young society women in the Red Cross motor corps, driving the

ambulances from early morning until way after midnight on some occasions, carrying patients rolled up in blankets down narrow stairs where the stretcher can not be used, and calling for masculine assistance only when absolutely necessary. Red Cross volunteers also assumed the care of convalescent children until they could be returned to their own homes, the Vogel summer home being opened for this purpose.

On Oct. 10, following the order of Dr. C. A. Harper of the state department of health, Dr. Ruhland issued an order closing theaters, movies, churches, public dances and other places of amusement. Subsequent orders closed the schools and put the ban on public meetings of all kinds.

The intensive publicity campaign included news stories and editorials in the daily papers, posters in public places, and a small four-page leaflet containing facts on the disease and its prevention told in simple words and short sentences. The health department issued this leaflet in several foreign languages as well as in English and circulated it widely. Several large corporations reprinted special editions for their own employees and posted warning notices conspicuously throughout the plants. Heads of welfare departments are taking an especially active part in the campaign. One of these welfare workers regards it as most significant that of the thousands of leaflets distributed among the men in that particular industry, none were thrown aside carelessly.

"Don't cough, don't sneeze, don't spit; use your handkerchief" cards were posted in every street car and there were also notices warning against overcrowding and calling attention to the fact that cars are disinfected daily and that transoms must be left open. The street car company printed its own cards for the campaign. Health department cards of warning against overcrowding were placed in all elevators. Boy Scouts aided the Council of Defense in the distribution of posters and literature.

The campaign is still on and so is the ban at the time of writing this article, (Oct. 31) but so far at least Milwaukee has escaped with a comparatively low number of cases and deaths. The high peak of cases was reached on Oct. 22 when 588 new cases were reported. The greatest number of deaths in one day was 35 on Oct. 28. Total cases from Sept. 26 to Oct. 29 inclusive were 8,105; total number of deaths, 315.

To the vigilance of the medical men, many of whom worked night and day, and to their faithfulness in reporting new cases promptly is due much of the credit for the control of the epidemic. The house to house canvas by the school teachers showed a total of 6000 cases of influenza and hard colds in the city at that time, with about 50 per cent of them under medical supervision, this indicating that the reporting of cases has been remarkably complete. Health department investigation of the cases in which no physician was employed proved that only 68 of them were serious. additional cases developed among the employes.

VALUE OF ISOLATION.

Practical demonstration of the value of isolation in the control and prevention of contagious diseases has been furnished by the experience at Muirdale, Milwaukee county's tuberculosis sanatorium, during the influenza epidemic. When the disease began to make its appearance among employees of the institution, Dr. Harry Cohn, acting superintendent, took immediate steps to prevent the spread of the disease. The five influenza cases among the employees were isolated and one nurse detailed to take care of them. On Oct. 9 an order went into effect forbidding the admission of visitors to the institution. No patients have been allowed to leave the sanatorium for visits to their homes. As a result there has not been a single influenza case among patients at Muirdale and no additional cases developed.

MORE AMMUNITION FOR THE DRIVE ON VENEREAL DISEASE.

One of the most important steps ever taken toward stamping out venereal diseases was that taken by the American Hospital Association at its recent annual meeting. The hospitals of the country, says *The Modern Hospital,* having awakened to the necessity of supporting the action of the War Department in this direction have adopted the following resolution:

"Resolved: That the American Hospital Association heartily endorses the program of the War Department for the control and treatment of venereal diseases, and that the hospitals of the country be urged to co-operate with this program in every way, and particularly by developing, or when necessary establishing, clinics for treating venereal diseases, and by opening their wards to patients with these diseases who require bed care."

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BOOK REVIEWS

BOOKS ON NURSING.

C. V. MOSBY COMPANY, ST. LOUIS.

NURSING IN DISEASES OF CHILDREN. By Carl G. Leo-Wolf, M. D., Buffalo, New York. Price $2.50.

This is a cloth bound volume of 314 pages with 72 illustrations. The medical and nursing professions will welcome any worthy work which specializes on the care of children. This is a subject which has received too little attention, the child too often being considered from both the medical and nursing standpoint as a small sized man.

The work covers such subjects as physiology, clothing, feeding, disturbances of nutrition, diseases caused by abnormal metabolism, the examination of the child, infectious and contagious diseases, private and public health nursing of children and mental hygiene. It can be recommended as a concise, well-written text book on the subject which has been written for the nurse.

SURGICAL AND WAR NURSING. By A. H. Barkley, M. D. Price $1.75.

This work in 208 pages covers the general subject of nursing with four added chapters on War Nursing. These last chapters take up the duties of the trained nurse in war service, the character and treatment of wounds and head injuries, gas infection and gas gangrene, etc. It is an elementary text book on the subject and should prove valuable at this time.

A TEXT BOOK OF PHYSIOLOGY FOR NURSES. By Drs. W. G. Christian and Charles C. Haskell, of the Medical College of Virginia. Price $1.75.

This is written as a text book for the average training school for nurses and can be recommended for this purpose. It is elementary and makes no claim for originality except in arrangement and treatment. An appendix contains an outline on some physical and chemical phenomena for students who have not received instruction on this subject.

GYMNASTIC TREATMENT FOR JOINT AND MUSCLE DISABILITIES. By Col. H. E. Dean, R. A. M. C. 146 pages, illustrated. Oxford University Press, 1918. Price $2.50.

This is an excellent little work on the subject. The author has been in constant service, specializing on this work for the past three and one-half years in the British Army. It gives the reader the benefit of his long experience in overcoming disabilities by gymnastic treatment. It covers gymnastic movements generally. The hand bag; Indian clubs; skipping rope; wrist rollers; pulling machines; vertical rope; parallel bars; sparred plank beam; leg exercise; wall bars; nautical wheel; games, etc. The illustrations make very plain the practical application of the exercises recommended. This work will be not only a valuable contribution to the treatment of our returned disabled soldiers but covers the treatment of deformities found in every day practice.

THE ANATOMY OF THE HUMAN BODY. By Henry Gray, F. R. S. 20th edition, thoroughly revised and re-edited by Warren H. Lewis, B. S., M. D., Johns Hopkins University. 1396 pages, illustrated with 1247 engravings. Published by Lea & Febiger, Philadelphia and New York. 1918. Cloth $7.50; leather $9.00.

The first English edition of Gray's Anatomy was published in 1858 and the first American edition followed the next year. During all this period this has undoubtedly been the most standard of text books on this subject. During these years great advances have been made especially in microscopic anatomy and the anatomy of the embryo. While the main text of this work has always remained a descriptive anatomy of the human body, successive additions have kept the work up to date and entire sections have been added covering the advances in these subjects. In this latest edition these special sections on embryology and histology have been distributed among the subjects under which they naturally belong. New matter on physiological anatomy, laws of bone architecture, the mechanics and variations of muscles have been added and occupy much of the space formerly devoted to the sections on applied anatomy. The sections on ductless glands and the nervous system have been rewritten. Numerous illustrations have been added wherever important points could be made more clear and the use of colored pictures has been more extensively used than heretofore. As a student's anatomy this work will continue to be recognized and appreciated as a standard which has not been excelled.

Time, the "Deadliest" Neutral Power.

"Time is a hesitating and a perplexed neutral. He has not yet decided which side he is going to swing his terrible scythe on. For the moment that scythe is striking both sides with terrible havoc. The hour will come when it will be swung finally on one side or the other. Time is the deadliest of all the neutral Powers. Let us see that we enlist him amongst our Allies. The only way to win time is not to lose time. You must not lose time in the Council Chamber, you must not lose time in the Departments which carry out the decrees of the Council, you must not lose time in the field, in the factory, or workshop. Act, and act in time. This is our appeal to you."

—*MR. LLOYD GEORGE.*
Carnarvon, February 3rd, 1917.

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ORIGINAL ARTICLES

THE APPLICATION OF PSYCHIATRY TO THE CLASSIFICATION OF DRAFT REGISTRANTS.*

BY DREW LUTEN, M. D.,

PAST ASSISTANT SURGEON, U. S. N., R. F.

GREAT LAKES, ILL.

In classifying the man power of the nation for service in the Fight for Democracy, many considerations serve as bases for classification. First, on the bases of *age,* the selective service law has divided the nation's manpower into two great groups, selecting those from 18 to 45 for special duties and leaving those above 45 to carry on other important work. The men selected are to be used in organizing a fighting force, whether in field, in factory, in transportation or in the military service; a nation organized to fight for life. In order to co-ordinate properly the needs of the various branches of this great fighting force and to see to it that the Army and the Navy are properly fed and supplied with implements of war, the men selected for special service are registered and classified. What considerations govern this classification? (a) The first obviously is whether the man will probably be an efficient soldier. (b) Second, will he, even if of good soldier material, be of more use in another capacity? (c) Third, has he dependents who might be a burden to the State if his support were cut off, or could his place be filled as well by another who has no dependents? Questions of health and fighting efficiency, occupation and dependency, therefore, must be given consideration. Granted then that he is to be one of the fighters in the field, so far as occupation and dependency are concerned, the man must be examined and classified on the basis of *efficiency as a soldier.* And this efficiency will depend on several factors: physique of body and of mind; health of eyes, ears, heart, lungs, nerves, mind, limbs, morals, etc., etc. It is as important that a soldier be able to see and hear as it is that he be big and strong enough to carry his equipment, or to endure a march. It is as important that he understand a command as it is that he hear it, and it is as necessary that he be kept from shell shock as it is that he avoid tuberculosis. A good fighter must have mental as well as physical stamia. Those who are entrusted with the classification, therefore, after giving due consideration to questions of occupation and dependency will examine each man physically and mentally; and it is with the various aspects of this mental examination and classification that this paper deals.

An abnormal heart or an abnormal hand may be either defective or diseased. It may be congenitially malformed or the defect may have originated later, from accident or otherwise. Or disease may be still active, and function be more or less disordered on that account. In like manner mental abnormality may be divided broadly into two great groups, Mental Defect and Mental Disease.

In the diagnosis of physical abnormalities, use is made of the history, symptoms, signs, various laboratory procedures, functional tests, etc. The function indeed of various organs is rather accurately measured by functional tests, and a certain standard is established. A man's vision is determined by what he can read, his hearing by what he can hear; and this list of functional tests is constantly being enlarged, so that now more or less satisfactory tests of kidneys, stomach, and even heart are being used. The physical examination of the heart, lungs, muscles, bones, etc., an examination of the urine and blood, if necessary, is easily accomplished and is a matter of a comparatively short time, but in an examination of the mind what physical signs, what chemical tests can be of service? What test of function or of quantity can be applied and what standard shall be used? The outlines and sounds of the heart are familiar, and composition of the blood is a matter of chemical determination, and a deviation

*Read before the State Medical Society of Wisconsin, Milwaukee, October 3, 1918.

from the normal is quickly noted. But what constitutes a normal mind? What standard can we establish so as to be able to detect deviations from the standard? How can we say whether the man to be classified has a normal mind, or a mind which is the seat of defect or of disease? How shall the registrants who are to be quickly classified as to vision, heart, weight, etc., be classified as to mentality?

Can such a classification be made? If it is possible, is it also practical? And if it is worth while, where shall it be done? How? These are the questions that occupy us.

Broadly speaking, this classification can be made. It is being made around us every day. Institutions are full of cases of imbecility, of dementia praecox, of paresis, of patients in short with defective or diseased minds. There are in every community people of varying degrees of brilliancy, people who are odd, cranks, people who in spite of ability in certain directions are lacking in other qualifications that are necessary for success in life. These are the Leaders of the community, the Average Citizens, the Morons, the Psychopaths and the Constitutional Inferiors; and while the community may not diagnose them correctly, may not classify correctly at least, these cases, yet the general opinion of a man's abilities, of his odditics, of his defects is usually about correct. And so mental classification can be made. This collective opinion, however has been arrived at slowly. Many actions of the man are taken into account and over a long period of time. What opportunities present themselves to the physician who has only a limited time for diagnosis? What means are at hand for mental diagnosis? The two groups mentioned above, mental defect and mental disease will be considered separately.

Let us consider first, the group of *Mental Disease.* In differential diagnosis, attention must be paid by the medical man, whether internist, psychiatrist or surgeon, to signs, symptoms, various tests, etc., etc., and the importance of careful physical examination by the psychiatrist is not for a moment minimized. And yet, as suggested above, in attempting to diagnose mental disease the help that can be derived from chemical tests and physical signs (aside indeed from inspection) is often very small. Dependence must be placed upon symptoms, and especially, upon the history. For it is the history that records the action of the mind in its relation to environment. Or in other words one might say that the *History is the Functional Test of the Mind.*

The history, however, of mental cases must be much more extensive than the usual medical history. It must go back further than the first manifestations of disease, and be indeed a chronological account of the individual's life; of his reaction to environment. The Draft Board has not the time for extensive routine histories and whatever opportunities it has for detecting cases of mental disease must be embraced within the scope of a few salient questions. Judging from the records of the Psychiatric Unit at Great Lakes the probabilities of a man's being inducted into service who is unfit because of mental disease are that the disease will be one of the following, in the order named: Constitutional Psychopathic State, Dementia Praecox, Manic Depressive Insanity and Epilepsy. The taking of routine histories that would indicate these diagnoses would require too much time. Questioning the registrant as to residence in an asylum and as to the occurrence of fits, however, would eliminate many of these cases and would eliminate almost all the epileptics. From July, 1917, to Sept. 15, 1918, there have been thirty cases of epilepsy brought to the attention of the Psychiatric Unit. Twenty-eight of these cases gave a history of attacks before enlistment, and in the other two no statement is made.

Another thing that has impressed the medical officers of the Unit is the number of cases who come into the service after discharge from an asylum as cured cases, that later exhibit signs of mental disease. It would seem that a history of residence in an asylum should almost always exclude a registrant from the service. No matter if he did have a recoverable disease and did recover, some strain caused his former "break"; and under the stress of military duty with its new environment and necessity for adjustment, and the probabilities of excessive strain upon a mental mechanism that has already proved unequal to a former strain, the probabilities of another "break" are almost always too great to admit of his entering the service. With the extension of the Draft to include cases from thirty-one to forty-five, more cases of Dementia Praecox who are in an inactive phase, and who have had asylum residence, will be registered.

In addition to the diseases mentioned above many cases of early paresis will come before the Draft Board since the extension of the age limit. In one community is a man whose moral sense, his wife thinks, is becoming a little obtuse. In another locality is a man who, his business associates think, is becoming reckless in business. In a few months these men's physicians will know, after the cases have finally come to them, that they have Paresis. Practically all the early paretics, whose cases have not yet come to the attention of physicians, have registered, and will come before the Draft Boards. About seventy-five per cent of these cases according to White, may be expected to show an abnormal pupil reflex, whether a typical Argyll Robertson pupil or not.

Granted then that the Draft Board can hardly be expected to take extensive psychiatric histories, but that by careful attention to a few routine questions and examinations it may exclude in the aggregate many cases of mental disease, let us consider the group of Mental Defect. The terms idiot, imbecile and moron are more or less accurately defined, but as indicated above, the quantative measurement of the mind is no easy matter, and many individuals are only a little above or a little below in mentality, whatever standard one may choose to measure them by. Even if we could measure by a simple standard the mentality of all men, where should we draw the line that would place all who come above it as normal and all who fall below as abnormal? One writer has said that a man may be a wise man in the county and a fool in Paris. And so any standard of mental measurements must be not like an albumen test or a blood count but must be more or less elastic. How shall the imbecile, the idiot, the moron be detected? Most cases indeed of the first two classes will not appear before the Draft Board, but many morons have registered and must be placed in one or another class. Looking at these matters rather from the view point of an internist, I had thought that the diagnosis of an imbecile or a moron would be an easy matter of inspection and a few questions. But such is not always the case. Often enough I have been surprised to find that a man of good appearance and who talked rapidly and with ease, showed upon more careful examination definite mental defects, defects that would prevent his carrying out an order that might be at all complicated and discharging any but the simplest duties; defects that would make him not only of no value in an emergency but also potentially harmful.

As stated above, careful classification of our manpower as to mental defects and abilities is as important as classification on the basis of bodily vigor. The best known system of mental measurements for defective individuals, perhaps, is that of Binet and Simon. Healy has made use of various tests and many others might be mentioned. All take considerable time. At Great Lakes we have selected for use as a routine seven well known tests. I have gone through our records in some two hundred diagnosed cases of mental defect with the idea of seeing if these records indicate that any one test is of sufficient value, alone, to justify its use by Draft Boards. These records furnish considerable evidence that some of these tests are of great value, that the value of others is slight; and a critical study of them may be worth while at some later time. At present it may be said that the most valuable ones of those that we use, seem to be the Double Cross line Test of Healy, the Knox Cube test and the Binet questions of comprehension. Ninety-three per cent of two hundred normal cases, studied as a control, succeeded on the Double Cross Line Test on the first or second trial, while only one of the two hundred normals failed completely after four trials. Of the mental defectives sixty-eight per cent failed completely and only thirty-one per cent succeeded in two trials. Whether or not, however, the use of these or some such tests as a routine by the Draft Boards, would be practicable is a matter of considerable doubt. The application of such tests on a wide scale involves much time and the question of malingering might become a very important one. That they might be used to advantage, however, by trained assistants in certain cases, is another question, and would seem worthy of consideration. Many cases might thus be eliminated by a more careful mental examination on the part of the Draft Board.

The remaining cases however, the border-line cases that escape the Board, must be detected and classified. Where and how shall this be done? The best place perhaps is in the psychiatric Units which are especially organized and equipped for the work. If the Psychiatric Unit can examine more or less completely all incoming recruits, many cases of mental disease and defect that have

escaped the notice of the Draft Board in its necessarily limited examination will be detected. These cases can be rejected before their equipment and training have been of much expense to the government. To what extent tests for different mental qualities may be of service in re-classifying the accepted men into special groups where the mental qualities they possess may be more readily utilized is an important question. It is, however, another matter and one that comes more properly under the domain of psychology than of psychiatry.

SUMMARY.

The proper application of psychiatry to the examination and classification of the nation's man power is obviously as important as is classification on the basis of physical qualifications. It is, however, inherently a more difficult matter and it requires much time. But mental classification can be made. On the basis of records of the Great Lakes Psychiatric Unit the more common cases of mental diseases that will come to the attention of the Draft Boards will be cases of Psychopathic Constitution, Dementia Praecox, Manic Depressive Insanity and Epilepsy. The extension of the Selective Service Law upward and downward will include more of these cases whose malady will not be at first apparent. More cases of General Paresis will also come for examination and classification. A few routine questions and examinations rigidly adherred to, will eliminate many of these cases.

Borderline cases of mental defect will not be easily detected. The question of the applicability of one or two tests, like the Double Cross Line Test of Healy or the Knox Cube Test to examinations by the Draft Boards, in certain cases, is suggested for consideration. The bulk of the work of eliminating the mentally defective probably must be done by the Psychiatric Units.

IT'S TIME TO GRIN.

The remark of a Milwaukee physician who, at a Medical Society meeting said: "In this condition, I feed my patients beans and other well cooked fruits," has been the fountain-head of many chortles.

To it may well be added the statement of another physician from the same place who, in a press interview is quoted as saying: "Often families can not supply their children with cream and other *condiments* which are really necessary for the child."

SOME OBSERVATIONS OF THE TREATMENT OF CLEFT PALATE.

BY M. N. FEDERSPIEL, B. Sc., D. D. S., M. D.,
PROF. OF ORAL SURGERY, MARQUETTE UNIVERSITY.
MILWAUKEE.

Harelip is a deformity of the upper lip of congenital origin, varying in different individuals in size and location. The nomenclature used in the

FIG. 1.
Hare's lip showing cleft in median line.

description of this defect is very misleading since the deformity does not resemble the cleft of the hare's lip, which is located in the median line bifurcating to each nostril (Fig. 1), but may affect any part of the lip. The cleft in the lip of the human being may exist as a mere notch in the vermilion border or it may continue into the floor of the nose, alveolar process and palate, forming a complete fissure in both the hard and soft portions of the latter.

FIG. 2.
Showing an alveolar cleft and cleft of lip.

An alveolar cleft (Fig. 2) seldom occurs in the absence of harelip. The modifications of this de-

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*Read before the Wisconsin Surgical Association, 1918 Meeting.

formity vary greatly in different patients. I have been unable to obtain any statistics concerning the proportions in which these different forms exist.

Cleft palate is either congenital or acquired and involves a part or all of the hard and soft palate. The variations in the extent of this defect are equally as great as those of harelip. In extreme

FIG. 3.
Showing protruding os incisivum attached to the tip of nose.

cases the cleft extends from the tip of the uvula to the anterior palatine canal, where the fissure bifurcates to communicate with a double alveolar cleft permitting the forward displacement of the central portion of the intermaxilla or os incisivum (See Fig. 3). This deformity is frequently called "wolfrachen" or "wolf's jaw" by the Germans.

The degrees of cleft palate may be classified under five main headings:

1. The cleft involves the hard and soft palate, the alveolar process, and the lip.

2. The cleft involves the hard and soft palate only, having the anterior alveolar process and the lip normal.

3. The cleft involves only a portion of the hard palate and all of the soft palate.

4. The cleft involves all of the soft palate only.

5. The cleft is a mere bifurcation of the uvula.

An accurate description of each defect that has come under my observation in literature and practice would require far too much space since the forms of cleft palate and the degree of the cleft are diversified.

ETIOLOGY.

Hypothesis and theories have been advanced to be almost as quickly rejected by later writers. At one time being very much influenced by the theory of maternal impressions and not having studied sufficiently the development of the oral nasal area in the embryo, I wrote an article which was published in the Dental Items of Interest entitled: *"Maternal Psychism—Its Effect Upon Dentition."* Since contributing that article my conclusions on the subject of psychism in its relation to foetal life have become somewhat altered. I am convinced by study and research work upon the etiology of cleft palate and harelip that maternal impressions cannot produce cleft of the palate after the ninth week of foetal development. Nevertheless I believe that the opinion of scientific men will be influenced by further research and study upon the subject of heredity, which is accepted by most men as a factor in producing these deformities.

I always try, in my practice, to detect by careful questioning some circumstances which might disclose the exact cause of the deformity. Frequently a mother tells me that she was frightened by seeing something that resembled the defect in her infant. This can hardly be considered since

FIG. 4.
Showing the vomer cut so that the os incisivum can be forced into its normal position.

the element of imagination enters in so strongly. Inquiry usually discloses in the great number of cases that some relative of the infant had or is suffering from a similar deformity.

In one family I operated on a brother and a sister, each of whom had a cleft of the soft palate. In another family I operated upon an eleven-month child who had a harelip and soon afterward another child was born who had a harelip and a complete cleft of the palate, but who lived only a

FIG. 5.

few weeks due to lack of the proper amount of nourishment. In this same family the third child was born normal. The fourth child had a complete cleft of the hard and soft palate, a double alveolar cleft, and a double harelip. This child I operated on and closed the alveolar cleft and harelip, the hard and soft palate will be operated on later.

Berry and Legg observed that a great difference in the ages of the parents will cause the children to be affected, but more often those born at the beginning or end of a large family.

Embryologists consider that morbid intra-uterine or placental conditions are the commonest causes of the want of union of the primary processes which go to form the palate.

It has been observed that other deformities, such as spina bifida, or club foot to be associated with harelip and cleft palate.

TREATMENT.

The treatment of harelip is surgical, the cleft of the palate is surgical, or it may be both surgical and mechanical or mechanical only. That depends on the judgment of the operator. Before attempting to remedy these defects the operator should be well informed on the advantages and disadvantages of surgical interference or the substituting of a mechanical appliance for the restoration of function.

I have had the opportunity in my experience to observe a large number of cases where surgery was resorted to for the correction of a cleft palate defect, the end result being anything but satisfactory. In other cases I have observed patients wearing an artificial palate and velum which did little or no good in the restoration of function.

I do not consider that a set of unalterable regulations can be established as to whether a mechanical substitute or surgical correction is best suited for the patient; but I do know that unless one has had a training in both surgery of cleft palate and mechanical restoration he cannot be in a position to judge what is best fitted for the patient's welfare. As I have said before cleft of the lip is corrected surgically. I always prefer to operate on patients having a harelip within a few weeks after birth. However, if the cleft involves the lip, alveolar process and palate, I close the alveolar cleft first.

The surgical repair of congenital clefts of the palate and alveolar process depends largely upon the degree of the deformity, the age of the patient, and whether the patient has sufficient vitality and resistance to withstand the shock of the operation or any complications which may arise. It is impossible to lay down any hard and fast rules as a guide in the treatment of these cases. The best age for the correction of the alveolar

FIG. 6.

cleft is, obviously, a few weeks after the birth of the child. The bones at this period are not fully

calcified and therefore can be easily brought together.

In patients who are suffering from a double alveolar cleft where the central portion of the os incisivum is displaced forward and attached to the tip of the nose, I usually perform a sub-mucous resection of the vomer by removing a V-shaped section. In other cases, it is only necessary to split the vomer to allow the septum to overlap when the protruding os incisivum is forced backwards (See Fig. 4). If, however, the os incisivum is undeveloped or at an age when tooth eruption has taken place it is impossible to follow the above method. Therefore, I consider it good surgery and far more practical to remove the protruding mass and prepare this area to act as a good stump for artificial restoration. This is best illustrated in the following case.

Name, W. V. M.; sex, male; age, 4 years; nativity, American; color, white; weight, 34 lbs.; complaint, harelip and cleft palate.

History—One of twins, youngest of family of five, three older children and twin brother normal. No history of harelip or cleft palate among relatives on father's side, mother, however, being left an orphan in early childhood, does not remember relatives.

FIG. 7.

Patient strong at birth, and suffered no children's diseases excepting cholera-infantum, was bottle-fed, always healthy and playful, and is now a well developed child.

Examination—A double cleft of the upper lip extending into each nostril (see Fig. 5), a double alveolar cleft (see Fig. 6), a very marked protruding premaxillary bone holding two central invisors (see Fig. 7). The clefts of the alveolar process united with a medium sized cleft of the hard and soft palate.

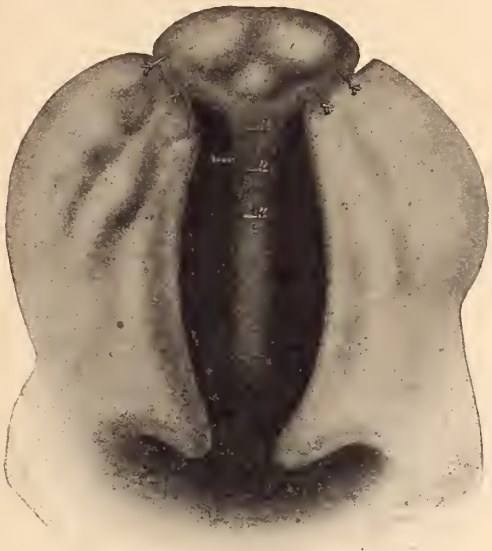

FIG. 8.

Showing the premaxillary bone wired in its new position.

The mouth was fair as to cleanliness, the mucous membrane normal, and no visible gingivitis or pericementitis. There were occlusal cavities in the lower second deciduous molars, the tonsils normal, and no enlarged adenoids.

Patient was referred to Marquette University Oral Surgery Clinic, Trinity Hospital April 2nd, 1918, and prepared to be operated April 4th, 1918.

Urinary analysis—normal.

Blood—normal.

Patient was admitted to operating room at 7:45 A. M., and put under ether anaesthesia.

Under the anaesthetic further examination revealed that the protruding mass contained two centrals which were tipped lingually. In this case, the two lateral halves of the upper jaw were very well developed and held the following well-developed deciduous teeth $\frac{5432}{2345}$, the occlusion of these being in normal mesio-distal relation.

The shifting of the protruding mass distally would not permit the closing of the alveolar cleft, for the mass in itself was too narrow to complete

FIG. 9.

the normal upper arch, and the anterior wall of the bone was found to be badly developed. The mass was ovoid in shape and stunted, evidently due to the absence of lateral support and failure to functionate.

In many cases of double alveolar clefts we find that the os incisivum is usually larger than the mass herein described. It forms a projecting tubercle, covered by smooth mucous membrane on the inner side, with the central portion of the upper lip attached anteriorly. In an infant it should contain the tooth buds of the temporary and permanent central incisors, arranged in pairs, one above the other. This type of oral deformity

FIG. 10.

is of the most pronounced kind, yet, when operated upon at an early age (from one to three months) and the os incisivum well developed and large enough to close the alveolar cleft, I do, as I said before, a submucous resection and cut the vomer. This permits the forcing of displaced os incisivum backward so as to form a satisfactory alveolar arch. The bone is then held in its new position by passing a silver wire through the vomor as illustrated in Fig. 8. In this way there is no injury done to the unerupted teeth. The borders of the alveolar cleft can then be cauterized several days later in order to get the tissues to unite in their new positions.

This, however, could not be done in this case since the os incisivum was undeveloped holding

FIG 11.

two centrals which were tipped lingually. Therefore, in view of the situation, Dr. A. Trigg, a prosthodontist, and I decided that it would be good surgery and far more practical to remove the protruding mass and prepare the vomer bone to act as a good stump for the artificial restoration of two central incisors. This was done under the following technique.

The muco-periostal flap on the labial and lingual surfaces was dissected and the mass, containing the tow deciduous centrals and the tooth buds of the permanent centrals, was removed (see Fig. 9). The Flaps of the soft tissues were then brought in contact and stitched on to the lateral halves of the jaw bone so as to close the anterior portion of the floor of the nose. There remained only the cleft of the hard and soft palate. Following this operation, the double cleft of the lip was closed by

bringing in contact the soft tissues which covered the protruding mass and the borders of the lip on each side. The vermilion surfaces were carefully joined and the alae of the nose were turned inward so as to give the boy the proper shaped

FIG. 12.

nostrils. Parafin silk was used to suture the soft tissues (see Figs. 10 and 11).

The wound was kept clean by gently washing it with boracic acid solution.

On the eighth day the stitches were removed (see Figs. 12 and 13), the lad was then able to function his lip normally.

FIG. 13.

In about six months or longer the cleft of the hard and soft palate will be closed. In order to keep the space open between the laterals, an orthodontic retaining wire will be fitted and adjusted so as to promote the space which, at a later date, can be restored with a well-fitted anchor denture holding two centrals.

In the treatment of single alveolar clefts it is customary for some operators to close the cleft

FIG. 14.

Showing undeveloped upper jaw from loss of teeth due to passing silver wires through jaw in infancy for repair of cleft palate.

under the Brophy technique at an age when the bones will yield, which is usually within 6 or 8 weeks after birth. This method of treatment, I admit, will close the cleft but I have abandoned such procedure because the passing of the wires through the alveolar process usually destroys the tooth buds of a number of teeth. The end result of this technique as the years go on has been proved to me that the loss of several teeth is a factor in robbing the upper jaw of normal development. It has a tendency to start a so-called progressive malocclusion and the jaw remaining stunted leaving the patient with an infantile jaw

FIG. 15.
Palatal view of same case shown in Fig. 14.

technically called a micrognathia. See (Figs. 14 and 15). The expression of the face is anything but satisfactory, the lower jam protrudes while the upper jaw seems to be sunken in. While it is

true that many of these cases can be benefited by orthodontic treatment in expanding the upper arch, orthodontists agree that to accomplish this, there must be sufficient number of teeth to produce a development of the jaw.

FIG. 16.
Showing loss of teeth caused by passing silver wires through jaw.

This can best be illustrated by studying (Fig. 16) showing the palatal view of a model of a young lad who was treated in infancy by a surgeon who closed the alveolar cleft under the Brophy technique. The bicuspids, the upper left lateral, and the upper right cuspid have been destroyed. The only permanent teeth he has are $\frac{621}{16}$, the remaining teeth are deciduous. The centrals are in marked lingo-version giving the boy the appearance of having a marked depression in the region of the upper lip, while the lower jaw seems to be protruding. In order to stimulate a development of the jaw by orthodontic treatment, it would be advantageous and the prognosis very favorable if the teeth had not been destroyed at the time the boy was operated upon.

Let us compare this case to (Figs. 17, 18, 19 and 20). This shows the result which can be achieved in developing the upper jaw, restoring the forces of mastication, improving the facial expression, and enlarging the nasal channel. In this case

FIG. 17.
Showing pinched face due to contracted upper arch and pronounced malocclusion.

there were sufficient number of teeth to fit the proper kind of appliances to obtain the right result. The object of comparing these two cases is to impress upon operators the importance of preserving the deciduous and permanent teeth when operating upon cleft palate cases, in order to permit further care, if necessary, through orthodontic means.

FIG. 18.
Showing palatal view—the contracted arch and the result obtained under orthodontic care.

For this reason I have discontinued closing the alveolar cleft by passing wire through the lateral halves of the jaw and forcibly closing the cleft.

In infants, I prefer to close the harelip first and depend upon the lip function to mold the arch. This is usually accomplished in about 18 to 24 months. I have had a number of cases showing the borders of the cleft of the alveolar process to

FIG. 19.
Showing improvement in facial expression.

come in contact much earlier. All that is necessary then is to cauterize the epithelial covering of each border so as to permit the parts to unite and then at a later time to close the palatal cleft which will be described later.

In some patients where the child is older than 8 weeks and the cleft is very wide, I use adhesive strips as illustrated in Fig. 21 for several weeks or longer. This is done by drawing the soft tissues of the lip together and attaching the tape, repeating this treatment every day until such time when I find that the lip can be closed without too much tension. If the patient is at an age when the tape or the closing of the lip will not permit narrowing the gap, I close the cleft by producing a green stick fracture of the alveolar process, thereby preserving the shape of the arch. This is, best illustrated in the following case:

Patient, E. S.; female, 9 years; excellent health; had congenital cleft of the lip, alveolar process and

FIG. 21.

soft palate (see Fig. 22). Notice the alveolar process is divided between the left central and the rudimentary left lateral. The alveolar process on the right side was turned outward and protruded to such an extent that it caused a distortion in that region. It was necessary to reconstruct the shape of the dental arch before doing anything further. The patient was anaesthetized under ether, an incision was made between the right deciduous cuspid and right permanent later. The muco-periostial flaps were raised and retracted, the exposed

FIG. 20.
Showing restoration of occlusion.

bone was cut one-half its thickness by a narrow long fissure bur; then by forcible pressure the protruding alveolar process containing the lateral and two centrals was brought in contact with the

FIG. 22.
A complete cleft palate and harelip.

alveolar process on the opposite side, thus producing a green stick fracture. The borders of the cleft were freshened and held together with an orthodontic appliance (see Fig. 23). The patient's mouth was kept as clean as possible and four weeks later after union had taken place, the appliance was removed. This operation restored to a fair degree the shape of the dental arch, and as a result the cleft of the lip became narrower. When I operated upon the patient the second time for the correction of the lip, I obtained better results than if I had attempted closing the lip before the shape of the dental arch had been restored (see Figs. 24 and 25).

After the correction of the alveolar cleft and the cleft of the lip, the patient is usually discharged

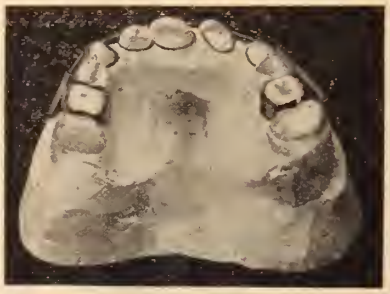

FIG. 23.
Showing method of immobilizing the fractured bone with an alignment wire to which the anterior teeth were ligated.

for about six months, at which time the cleft of the palate is closed.

In order to fully appreciate my method in the relief of lateral tension in cleft palate operations, I will describe the technique of combined uranoplasty and staphylorraphy. The method universally employed is Langenbeck's which consists of the following steps:

FIG. 24.
Hare lip. Note the width of the cleft. This same cleft became more narrow after the alveolar cleft was closed.

1st. Freeing of muco-periosteal flaps.
2nd. Freshening the edges of the cleft.
3rd. Placing and tying of sutures.
4th. Relief of lateral tension.

FREEING OF THE MUCO-PERIOSTEAL FLAPS.

This procedure is accomplished by cutting the mucous membrane along the entire borders of the cleft and separating the soft tissue by periosteal elevators and cutting the tissue loose from the distal surface of the horizontal plates of the palate

FIG. 25.
Another view of same patient after being operated.

bone. This should be done with great care in order to prevent tearing or lacerating, which may seriously impair nutrition. Naturally this brings on considerable hemorrhage which can be stopped

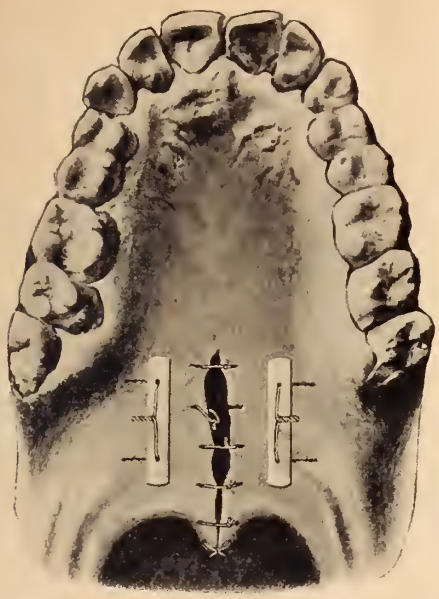

FIG. 26.
Showing lead plates with wire ligatures cutting through the soft tissues.

by firmly pressing a sponge gauze against the bleeding surface. It is not always possible to avoid wounding the anterior palatine and especially the posterior palatine artery. Should one of the vessels be nicked it will cause severe and prolonged hemorrhage. It is therefore better to completely divide the vessel so that it will contract as it ends, thereby overcoming protracted bleeding.

FRESHENING THE EDGES OF THE CLEFT.

This can best be accomplished by grasping the uvula on one side with a catch forcep and putting tension on the soft tissues, then with a very sharp thin-bladed knife cut a thin marginal strip along the entire flap from the uvula to the apex of the cleft. This same procedure is to be carried out on the opposite side. The freshened surface should be cut square with the flap tissue. A beveled surface is conducive to inviting failure. If the raw surfaces are cut square, it is an easy

FIG. 27.
Type A. Author's tension plates.

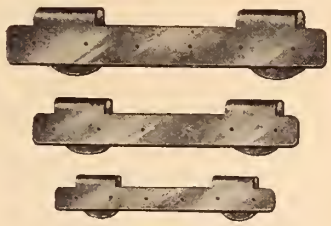

FIG. 28.
Type B. Author's tension plates.

FIG. 29.

matter to bring them together in close apposition which will enable rapid union during the healing period. In cases where there seems to be a short-

FIG. 30.

FIG. 31.

age of tissue in the soft palate I prefer to split the border of the velum about one-eighth of an inch and then unite the raw surfaces.

PLACING AND TYING OF SUTURES.

Various kinds of suture material have been adopted for holding the pared edges together, such as silk, horse-hair, linen, catgut, wire, etc. Personally I do not believe that the difference in value of the above named suture material is of

any great consequence, providing the operator does not depend upon the same to overcome lateral tension. Sir William Ferguson, in 1844, recognized that the tension on the ligatures frequently

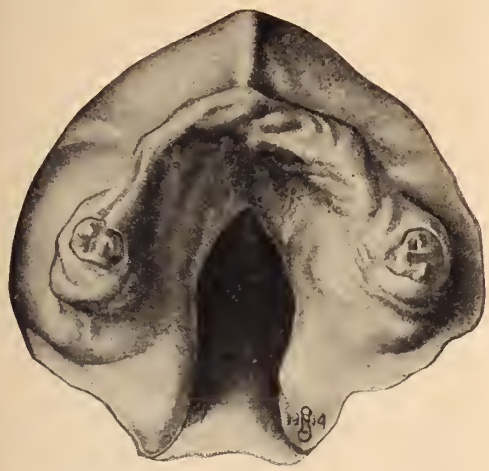

FIG. 32.

invited failure, either through their cutting out or by shutting off the circulation, thereby bringing on starvation necrosis and infection. To overcome this tension Ferguson divided the levator palati, the palato-glossi, and the palato-pharyngeal muscles. In 1860 Dr. Agnew believed that the tensor palati muscles were responsible by pulling the newly approximated surfaces on the soft palate apart, thus causing the sutures to pull out. Therefore he advocated making an incision close to the

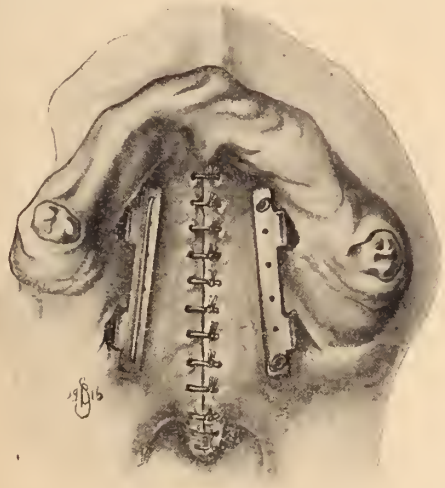

FIG. 33.

hamular process of the sphenoid bone, and in this way overcoming tension. For a long time these methods were extensively adopted by operators in this and foreign countries. The end results were not satisfactory. This was pointed out in a paper by Dr. T. W. Brophy in 1901 in which he says, "The formation of cicatrices following incision renders the soft palate thick and unyielding, so that its function is performed imperfectly." Dr. Brophy finds it unnecessary to cut the muscles on either side, it was he who introduced the application of lead plates. The advantages claimed for these plates are to render the palate inflexible and the prevention of the cutting out of the sutures. Dr. Blair reports that he has discontinued the use of lead plates as a retention device because they occasionally caused sloughing, in spite of every care; he depends entirely upon the sufficient free-

FIG. 34.

ing of the flaps. In my experiences I have never found that the plates cause sloughing, but that they did not prevent the cutting out of the sutures (see Fig. 26). They are, however, of a distant advantage in rendering the palate inflexible. In order to prevent the cutting of the suture through the soft tissue I have devised a new tension plate which will prevent the suture material from cutting out and at the same time relieve the tension as well as render the palatal tissues inflexible. These plates are made from non-corrosive metal B. I. B. American gauge 22, in various sizes and types (see Figs. 27 and 28).

The object of these plates is to prevent the cutting out of the wire ligature which frequently

happens with the Brophy plates. In order to fit these plates it is necessary to make a small incision near the gingival border of the last molar, being careful not to cut the palatine artery. (The operator must take into consideration the degree of the cleft, the position of the blood vessels and the type of plate that best suits his purpose.) The incision should be of sufficient length to permit the flange of the plate to enter and lie between the palatal bone and soft tissue. Previous to fitting these plates it is necessary to pass silver wire (American gauge 24) through the mucco-periosteal flaps and then through the holes in the plates. The ends of the wire are then passed through perforated lead shot and made tense by pulling the wire and crushing the shot after the borders of the flaps can be approximated without tension. After this is done I denude the border of the cleft and then place and tie the coaptating sutures after the McCurdy method.

While to the beginner it is rather a difficult procedure to properly fit these plates he can, with a little patience, soon master the technic of this simple procedure as an aid in obtaining uniform anatomical, as well as physiological results.

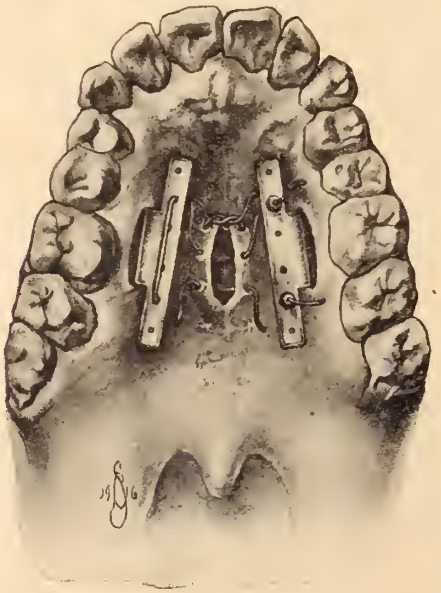

FIG. 35.

Fig. 29 illustrates the cleft of the hard and soft palate. Fig. 30 shows the same case with the plates in position. Fig. 31 shows the same case and the operation completed. These plates are now relieving the center ligatures so that healing can take place without tension.

Fig. 32 shows an extensive cleft of the hard and soft palate. This patient, for years, had been wearing an obturator. Fig. 33 shows same case with the palatal opening closed and held so with type B tension plates. Healing took place rapidly

FIG. 36.

in this case and the patient was discharged ten days after the operation.

Fig. 34 illustrates the so-called "button-hole" opening in the center of the palate. This form of opening usually is the end result of an attempt to close the hard and soft palate. Figs. 35 and 36 show the advantage of using the author's type A tension plates for closing the opening shown in Fig. 34.

THE DESPISED FEMALE WRITER.

It's too bad F. Marion Crawford isn't around to enjoy the experience of Miss Ola M. Weyth, the American Library Association's librarian in the hospital at Camp Wadsworth. Miss Weyth stopped before one of the patients and offered him a book.

"Who wrote it?" the patient demanded.

"F. Marion Crawford," was the reply.

"Not for me," said the soldier. "I never could stomach books written by women."

"But F. Marion Crawford isn't a woman," he was told.

"The deuce she ain't," said the soldier. "Then what is she?"

He finally accepted a "sample book," liked the sample and called for everything "She wrote."

STRABISMUS CONVERGENCE, ITS EARLY RECOGNITION AND TREATMENT IN YOUNG CHILDREN.

BY P. H. DERNEHL, B. S., M. D., F. A. C. S.,

MILWAUKEE.

The early recognition and treatment of squint and the problems which it entails are apparently not sufficiently appreciated by the general medical practitioner, and we need not wonder, that we meet with so many cases of neglected squint in patients, who might have had this condition corrected in early childhood to their cosmetic, economic and visual advantage and benefit. Let it not be interpreted that I seek to place, even a trace of disparagement at the door of the general practitioner, much less to depreciate his efforts in behalf of ophthalmology, the fault rests not solely at his door, but with the bold and open defects in ophthalmological training.

Many medical institutions, even at the present day, do not recognize that ophthalmology embraces a host of special and important facts and processes, that should be taught and held as part and parcel of general medical knowledge. A survey of the curricculums demonstrates only too clearly the stepbrotherly place accorded this branch of medical learning. When taught it is usually granted a seat in the back row, and is given as a series of lectures at the close of a medical course, rarely as a thorough laboratory course with inculcated systematic training, without which, sound clinical knowledge cannot be attained, therefore too perhaps do we so rarely find the ophthalmoscope, reposing as it deserves to, at the side of the stethoscope and the clinical thermometer in the equipment bag of the physician or surgeon.

The story of strabismus presents one of the most interesting chapters in medical history, for unquestionably the strongest of human prejudices against disconcerting and repellant abnormities in the human form are those associated with the eyes, and from earliest times, through the dark middle ages and up to comparatively recent times, and even now among many of the savages and oriental races, the belief in the malevolence and the hypnotic powers of the *"evil eye"* still pertains.

That the possessor of such an *"evil eye"* was and is but often enough an innocent "squinter" there can be no doubt. In the early medical writings only meagre space is given to strabismus. It was largely held to be a permanent deformity—Hippocrates makes mention of it only briefly and held epilepsy to be the main causal agent. The Arabians refer to it and give interesting assignments for its treatment, Celsus, Paulus Aeginate and others of their time speak of it and recommend their *"cures"*. Ambroise Paré in particular devoted much attention and study to it, and what he voiced can be read today with profit and pleasure by every medical student. Gradually more thought and study was devoted to squint and what may be termed a new era met with its conception largely through the classical, experimental studies of Sir Charles Bell (1774-1842), who by cutting the various muscles of the eye and noting the effect upon the ocular movements, opened at once a field for research in respect to the physiology and anatomy of the nerves and their influences on the movements of the eyes, which proved most far reaching in its results.

This period inaugurated that of the actual study and surgical treatment of strabismus. In connection with it we meet with two names, alike well known in the domain of surgery and ophthalmology. George Friedrich Louis Strohmeyer of Hanover, professor at Erlangen, Munich, Freiburg and Kiel, the father of modern military surgery in Germany, who practically created the modern surgery of the locomoter system by applying subcutaneous tenotomy to all deformities, depending upon muscular defects, was the first to suggest and describe the operation for strabismus. His contemporary Johan Friedrich Diefferbach of Königsberg, surgeon to the Charité (Berlin), was the first to severe surgically the tendons of the eye muscles for strabismus.

The success with which he met, in this operation, led him into the fallacy to attempt a cure for stammering by dividing subcutaneously the lingual muscles. He was extremely successful in tenotomies, skin grafting and orthopedic surgery, and was a pioneer in transplantations and experimental surgery on animals. Following these discoveries and successes which were hailed with great eclat alike in the medical journals and the daily press, the operation for strabismus became at once so popular, that it degenerated into a fad. A reaction consequently soon made itself felt as the untoward results of much ruthless operating became more and more manifest.

It was at this stage of renouncement, that the genious and authority of A. von Graefe guided the surgeons back into the channels of conservatism. The operative principles and methods of Dieffenbach, modified by von Graefe are practically those employed today in our "modern procedures"—so-called—varying in minor details and technique, more or less fanciful, as they appeal to the tastes or whims of the operators. Within the last half century, however, our precise anatomical and physiological knowledge of the muscles of the eye has been greatly furthered and enhanced, large'y through the efforts of American students, and with a better understanding of strabismus, resulting from these labors, conservative methods, methods of non-surgical treatment have replaced, and fortu nately so, very largely, the lid retractor, forceps and scissors, especially so before the period of adolescence.

It is very common to meet with many curious conceptions in the lay minds suggestive of the cause of squint, and now and then a moss bedecked disciple of Aesculapius concurs with them in believing it the result of the child sleeping persistently upon one side, the habit of imitating its nurse, or having had one eye bandaged—or gazing into bright light or at an object suspended closely before its eyes, teething, measles, nervous or gastric upsets and so forth. True, a squint may become apparent following or during fevers, mental shocks and other pathological states, and it cannot be denied, that in such states or following in the wake of them, we not infrequently meet with an intermittent convergent strabismus, or one which is not quite manifest may appear suddenly, continue for a few days or weeks, only again to disappear, quite as it came.

Among the various theories inaugurated to explain strabismus, the so-called *"muscle theory"*, held sway for a long time, this, in brief, taught that the condition of which we speak, rested upon a congenital shortening of the respective rectus internus or upon a lengthening or weakening of the corresponding externus. This theory has been for long completely disproved and needs no further comment, other than merely to allude to the fact that a very subordinate proportion of cases of squint do develop out of a true muscular defect, such as those resting upon a primitive paralysis, or upon a congenital weakness or over development of any of the recti muscles, or malformations of the orbit. Secondary changes in the muscles and facia of course must be granted in some cases, hardly though in young children, depending upon a long continuance of the deviation. Reference has already been made to what ruthless operative enthusiasm this muscle theory gave rise.

Fortunately this theory and its fallacies did not long endure. Donders, a Dutch ophthalmologist, Albrecht von Graefe and Sir William Bowman, the noted English ophthalmologist—a trio between whom a life long intimate friendship endured, through their joint labors virtually threw a new light upon the science of ophthalmology. Be it not forgotten, however, that the invention of the ophthalmoscope, by Herman von Helmholtz in 1851, did more perhaps than all else to further the study of ophthalmology and make it an exact science, to say nothing of the great classical work of von Helmholtz on physiological optics. Donders in 1864 published his celebrated work, not in Dutch, but in English (by the New Sydenham Society). "The Amomolies of Refraction and Accommodation," which as a contribution to physiological optics, may be ranked not beneath the labors of Helmholtz in that field.

This monumental work within a short period underwent a German, an Italian and a French translation, and even today can assert and should be given its place in every well selected ophthalmological library. This epoch making work, holding Donders' theory on squint, has not been wholly superseded even to the present day. Donder's theory regarding strabismus convergence, met with ready acceptance, and supported by von Graefe's great authority had a profound influence in inaugurating moderate and rational surgical treatment, and in introducing methods that strove to promote curative measures, based upon the correction of errors in refraction and accommodation.

Donders propounded that practically all cases of convergent squint resulted from a state of hyperopia or far sightedness. Stripped of its technicalities, his theory may be given in a simple mnemonic form. If one who has normal vision (an emmetrope) views an object—let us select a star—at an infinite distance—the axis of his lines of vision are practically parallel and he does not need to accommodate, that is when these parallel rays enter an emmetropic eye they undergo refraction as they pass through the different refractive media of the eye, such that they are brought

to a focus upon the retina, and as all rays from every point of such a distant object act likewise, a complete image of the object is formed on the retina, and the object of choice—the star—is distinctly seen. If now, the emmetrope, could bring this star, reduced to, say the size of a pin's head, closely before his eyes, he must, in order to see it clearly, turn his eyes inwards—*converge*—and at the same time he must accommodate for clear vision, and because the rays, which enter the eye from this near object are sensibly divergent, it is immediately evident, that the refraction, which exactly suffices to bring parallel rays to a focus upon the retina, will not focus these divergent rays. However, by means of the contraction of the ciliary muscle, the lens becomes more convex, thereby increasing its power of refraction (accommodation) and by this contrivance these divergent rays are also brought to a focus. The seeer in order that both visual axes may be directed alike to the same object and focus upon like places in both retinae, must converge. These two functions, accommodation and convergence have, through habit and heredity become associated. So then, in order to see clearly, at close range convergence and accommodation must be simultaneously executed. A hypermetrope or far sighted person, however, must accommodate, to view an object at infinity—and in order to see distinctly, at any distance, must accommodate to an extent commensurate with the degree of his far sightedness. In near vision he must then, *"a priori"*—accommodate both for his inherent farsightedness and that necessary to make distinct the object viewed at close range. At the same time a proportionate convergence must take place, and in hyperopes this must of necessity be excessive, on account of the relation it bears to the accommodation. This abnormal convergence which depends upon increased accommodation led Donders to believe that herein the cause of convergent strabismus was to be sought and on these grounds he advised glasses for farsightedness to correct the squint. More should be said on this theory for its better elucidation, but in the narrow confines of a brief essay its most salient points can only be touched upon.

As is the usual fate of theories this of Donders was destined to meet with disprovals. It was pointed out that, though this relation of strabismus convergence to accommodation and convergence (hyperopia) plays an important part, as an etiological factor, and that the majority of squinters are hyperopes, that, just so true is it, that, the great majority of hyperopes do not squint and that among the highest degrees of hyperopia permanent strabismus convergence is comparatively rare. Further there is only a relatively small group of cases in whom the convergence can be made to disappear by correcting the hyperopia with glasses, so if strabismus convergence were merely the result of faulty accommodation, then proper glasses or the mere paralyzing of the accommodation with a mydriatic would eliminate the convergence excess. Then to, we frequently have myopia or emmetropia pertaining in convergent squint, and finally it is not uncommon to find the angle of deviation much greater than it should be, commensurate with the accommodation. This theory of Donders has gradually yielded ground to, and has been superseded by the so-called *"Fusion Theory"*, which is the generally accepted theory of today. For its inception, development and application we are largely indebted to the English School—Priestly Smith—Maddox, and especially Claude Worth, who merits most credit and under whose name this theory is also known.

The term *"fusion"* as generally applied and understood in ophthalmology enjoins a word of elucidation. We know that corresponding points have their image projected to the same point in space, also, that two objects cannot occupy the same space at the same time; therefore, the mind must regard them as one. Inherently we are possessed of a strong want for single vision, which is expressed by an equally strong, subconscious desire to bring together or "fuse" any double image of the same object, even though but one of these engages our attention. If any one of these images differs in any form or manner from the other, this desire is at once abolished, and further, as we cannot move one eye independent of the other, we must carry out an associated movement with both eyes, until the one eye has fixed the object. In this act the other eye must be deviated inwards still more. The seeing eye "fixes", the deviated eye "squints", there is no fusion. Thus we may reach in a simple way an explanation, if we but assume, that the underlying factor is a faulty or absent fusion. Worth sums up his theory in the following succinct and graphic words.

"In a case of convergent squint there is in addition to the most obvious symptom, the de-

formity, always a defect of the fusion faculty, and there is nearly always a suppression of the vision of the deviating eye. In the human infant, the motor co-ordinations of the eyes are already partially developed at birth. During the first few months of life these serve (in the absence of any disturbing influence) to maintain approximately the normal relative directions of the eyes. Soon the fusion faculty begins to develop. I have found distinct evidence of binocular vision in the sixth month. Normally the development of the fusion faculty is well advanced by the twelfth month, and complete before the end of the sixth year. When the fusion faculty has begun to develop, the instinctive tendency to blend the images formed in the two eyes—the "desire for binocular vision" as it is called—will keep the eyes "straight". When the fusion faculty is fairly well developed, neither hypermetropia, nor anisometropia, nor heterophoria can cause squint. In fact, then, nothing but an actual muscular paralysis can cause an eye to deviate, in which case the resulting diplopia is intolerable. Sometimes, however, owing to a congenital defect the fusion faculty developes later than it should, or it developes very imperfectly, or it may never develop at all. Then, in this case, there is nothing but the motor co-ordination to preserve the normal relative directions of the eye, and anything which disturbs the balance of these co-ordinations will cause a permanent squint. Thus the essential cause of squint is a defect of the fusion faculty."

The provocations then, underlying the etiology of squint in the light of Worth's theory are those already alluded to. Hyperopia with its tendency to abnormal dynamic convergence, plays the most important role, and upon this factor, as did Donders—Worth lays great stress, and points out the following facts: If a deficient fusion sense (hyperopia) maintains, the eyes yielding to this, a convergent squint is established. At first this abnormal convergence is purely dynamic—that is a permanent squint is not yet manifest—and it may appear only now and then—often only when the child is weary from play. A static convergence is "nil", however, in course of time this exercise, if we may term it so, of dynamic function or convergence, promotes the development of a permanent or static convergence—and a permanent squint is established, even with the eyes accommodating perfectly when at rest. If the fusion sense is present, but feeble, it may, as Worth points out, be strong enough to resist, but with a stimulated accommodation it will give way—as for instance in the first acts in reading.

"During the first weeks of life even in cases of very high hyperopia, the motor co-ordinations suffice to maintain approximately the normal relative directions of the eyes, until the developing fusion faculty takes control and makes everything safe. Probably the infant does not use his accommodation much at this early period."

Anisometropia—in this connection, is of no small importance—by this term is meant, a difference in refraction of the two eyes—one eye may be normal the other farsighted, nearsighted, or astigmatic, in fact all possible combinations may hold—it may be a condition congenital or acquired. In this connection it may be added, that many persons, are quite unaware that they do not see equally well with both eyes, often not at a mature age or until tests for vision are made. If the differences in refraction are not too great, binocular vision appears in no manner disturbed by it, as both visual images, even though not equally distinct, are superimposed and made to coalesce. In high degrees, this of course cannot hold, and then as must be evident, from what has gone before, strabismus frequently sets in.

In the majority of slight cases of anisometropia, met with in mature life, strabismus is not found; of this more will be said. Malnutrition, fevers, prolonged illnesses, predispose to strabismus, though in the majority of such cases, a hyperopia already pertains. With these as etiological factors, little patients are often brought for treatment, frequently the squint is still dynamic—and just here the attending physician can do most good. Every such child, weakened and reduced in its vitality, that manifests even the very slightest ocular imbalance or other visual disturbances should be given immediate care by the specialist. In many cases the squint is merely periodic and will disappear as the child grows stronger and the "house physician" is *"right"* and undeservedly is credited with "good sense"—but in many cases such favorable out come may not follow and our "good doctor" is minus a greater or lesser bit of his reputation in the family, and besides has the "cross fire" look of his little patient as a reminder of his poor judgment.

Worth explains the mode of origin of these

squints as follows: "The fusion sense is defective but the motor co-ordination or some slight degree of fusion sense has hitherto sufficed to prevent the occurrence of deviation. During convalescence the child is given picture books. Owing to the muscular enfeeblement caused by his illness he is unable to accommodate as well as formerly. The excessive effort of accommodation upsets the unstable equilibrium, and what was merely a premonitary occasional squint becomes constant."

Nervous disturbances, injuries at birth and other minor causes naturally operate in a greater or smaller degree. Hereditary influences in promoting squint are perhaps greater than generally conceded—the writer is firmly convinced of the important bearing of heredity in this connection, and that exact statistics would bear this out and present us with interesting and valuable results. Careful inquiries into the family histories of a large number of squinters which have been under my care in my private practice and as ophthalmologist to the Milwaukee Public Schools, in which latter capacity, I have had opportunity to examine a large number of squinters, have convinced me, that as a predisposing factor, a hereditary, inherent weakness of the fusion faculty, is transmitted in the majority of cases, coupled in many with an inherited hyperopia.

One further problem, which bears an important relation to squint, needs be briefly touched upon, that of *"amblyopia"*. By this term we understand a state of reduction in the acuteness of vision, which cannot be relieved by glasses and which is not dependent upon any visible changes in the eye; it may attain various degrees from partial to almost total loss of vision—*amarosis*. It is either congenital or acquired—amblyopia exanopsia. As to which of these two types pertains is frequently almost impossible to decide in young children, and it is not improbable, that we more often, than we may be led to believe, find the one superimposed upon the other, in fact, it is often a difficult matter to determine in infancy and early childhood, whether an amblyopic state is present. Statistics show that from 30-70 per cent of all squinting eyes are amblyopic, as to what per cent of these are congenital and what per cent acquired is difficult, perhaps impossible to determine with any degree of certainty and upon this question opinions differ widely. Within the confines of this brief paper a discussion of cause and effect cannot be gone into, important though they are from a prognostic standpoint. Briefly in the congenital type, the cause is to be sought in faulty development, as the cones at the fovea, in the optic nerve, in the visual centers of the brain or in faulty development of other of the deeper membranes.

One factor in this connection, to which apparently not enough importance is attached, is the great frequency, and the harm wrought by retinal hemorrhage in the new born, as a result of circulatory disturbances within the child's skull during birth, especially in prolonged labors and in cases of instrumental deliveries. It is estimated, that hemorrhages occur in from 21 to 32 per cent of the new born. I am inclined to estimate them at even a higher figure. Though rapid absorbtion is the rule, yet we know not, even though no trace of hemorrhage or its presence remains, what damage to the central vision has been left behind. The full visual power of such eyes cannot be brought back to normal.

Under this caption of amblyopia some students also choose to group those cases with unilateral high refractive errors, i. e. extreme hyperopia, myopia, astigmatism and so forth. In amblyopia exanopsia—loss of vision from disuse—the category includes of course any obstacle to vision such as prevents the formation of a sharp image upon the retina, as opacities in, or upon the medias. Such, however, do not concern us in this connection. However, that type of amblyopia which has developed in an eye, that has squinted since childhood and in which the amblyopia has arisen as a result of the strabismus, (there are those and perhaps on good grounds—who maintain that the amblyopia promotes the strabismus) merits a word of comment, for here again the general practitioner, the house physician, receives his call for ready action, to prevent, certainly in many cases, at least, a possible loss of vision in the squinting or tending to squint eye of his patient. In such cases the very fact of the tendency of the eyes to deviate indicates—that in the eye of the child the preception of the retinal image of the squint tending eye is mentally suppressed and the eye thus purposely excluded from participation in the act of vision. The retina in the eye involved fails to attain that stage of delicate function requisite for a normal eye, and that, that function previously acquired, will be lost to a greater or less extent, even though absolute blindness will not supervene.

The younger the child, other things being equal, the more rapid is the visual deterioration from disuse. The following impressive lines taken from Worth will serve to lend weight to these last remarks. "In a case of convergent squints, even though the vision of each eye separately be perfect, the patient will, when both eyes are open, only see with the "straight" eye. The impressions received by the deviating eye are mentally "suppressed". In the case of a young child with a constant unilateral squint, the result of this disuse of the deviating eye is that its visual acuity gradually deteriorates. This deterioration from disuse is the more rapid the younger the child so

much so that it is commonly believed that an eye which squints in infancy is necessarily very blind. This is not so. A child with good vision in each eye who developes a constant unilateral squint at the age of six or eight months, will, in the absence of proper treatment become rapidly blind in the squinting eye. This loss of vision in the infant's deviating eye is so rapid that the power of central fixation is often lost within eight or ten weeks. In an eye which begins to squint constantly at the age of say, eighteen months, the progress of blindness is rapid, but much less so than in a younger child. At least five or six months usually elapse before the eye loses the power of central fixation. An eye which begins to deviate constantly at the age of three years seldom quite loses the power of central fixation in less than a year. I have never seen central fixation lost in a case in which the squint had first appeared after six years of age. After six years amblyopia exanopsia seldom takes place to any great extent."

Hence again, I beg leave to call the attention of the general practitioner and especially the pediatrician to the importance of the early recognition of these cases and the imperative need of early treatment, that states of amblyopia and squint may through proper treatment be cured or in a measure mitigated.

TREATMENT.

The title of this brief paper, precludes a discussion of treatment of the mature squinter, suffice it to say, that in the adult, operation alone is indicated and not truly as a therapeutic measure. The very best, that we can hope to attain in adults, is a cosmetic result, and frequently this is not a complete success. In the great majority of cases we can straighten the squinting eye, that is all—fusion and vision cannot be restored, the squinting eye has become amblyopic from disuse. Its owner has sacrificed the sight and a regaining of it or a mentionable part of it, is so rare that we may disregard such an eventuality entirely.

In the infant and young child however therapeutic measures promise and achieve most brilliant results, not in all, but in the largest majority of cases and no child should be denied the opportunity of an early treatment, for herein lies the greatest chance for a therapeutic success. Let it be understood that no child is too young for treatment. From what has been said, i. e. the rapid loss of visual acuity which occurs in the squinting eye, makes it imperative that treatment is called for at once, and the sooner that this is inaugurated the more certain is the attainment of a "cure". The most cardinal factor, underlying treatment, and the measures to be most assiduously entered upon are primarily to prevent a deterioration of the vision of the squinting eye, an emblyopia — these efforts must need be associated with an endeavor to remove the cause of the squint by a training of the fusion sense, thereby to restore the visual axis to their normal. To accomplish this we can divide the measures employed into non-surgical and surgical. It is with the former, however, in the case of the infant and growing child, that we need practically entirely

concern ourselves. The purely surgical side can be dismissed with a few words, and will be referred to again.

Under the first caption, the non-surgical treatment, most imperative is a correction of any error of refraction, this, is to be followed, if necessary by an occlusion of the fixing eye or a paralizing of its accommodation and withal an attempt to recreate the fusion sense. The optical correction in children must, of necessity, be effected by skiascopy—retinoscopy or the so-called shadow test; this established, glasses to correct the error are ordered and should be worn constantly. No child is too young to wear glasses, my youngest patient was eleven months old, and wore her glasses with no apparent discomfort. Glasses and their proper construction are of the greatest importance. I have tried to invent such as may meet with all requirements in the young and believe to have succeeded in so doing.

The opposition I have almost always met with in inducing them to be worn by the very young, was not on the part of the patient, but on the part of parents. "They will crack or splinter and cut the eye"—"They won't stay on"—"They will cut the skin"—"They look so horrid"—as though a squinting eye were a thing more beautiful. All such objections, however, are nugatory, they must be, and can easily be ruled out. As to splintering; if properly constructed this will not happen—at most the lenses may crack, or chip, but will not splinter, and the broken pieces cut the eye, they may chip at the edges, but any force that can produce such an effect upon the lense while worn, would certainly injure the naked and unprotected eye to a much greater extent.

Regarding the age at which they may be worn the very youngest may be comfortably fitted with properly constructed frames, such as I have devised and as are herewith described. I do not claim priority for their construction, but believe they are better adapted for the purpose intended than any I have seen in use or described. It is important, first of all, to have the frames accurately fitted and made of good quality material. Those which I prescribe are made of German silver or white metal, an alloy of German silver and aluminum. The cost is trivial. They can be made to last a long time, and are strong and light in weight. I do not favor the use of steel frames, they are bound to rust in time, and in young children, who tend to prespire freely, this is certain to be, besides the metal in contact with the skin tends to mark this. Circular lenses are given preference, to prevent the child from peering over them; these must of course, be very firmly secured in the rim to avoid their turning, this is especially important if the lenses are ground with an astigmatic axis. Careful centering is imperative. The glasses should be worn as closely to the eyes as possible, without being touched by the lashes. The frame consists of a strong bridge piece, which rests upon a broad and flat bar of celluloid, accurately fitted to the bridge of the child's nose. By its means all undue pressure upon the bridge is

eliminated, which is of no small importance (Plate IV). The lenses are set firmly in metal rims—rimless glasses must not be worn. The bows are straight, firm and unyielding, and terminate just above the ear (Plates IV and II). Plates one and two portray a child twenty-two months of age wearing these frames. The bows terminate in a triangular loop (Plates III and IV), and it will be seen, that at the base and in the apex of the triangle is a small plate with screw holes through each of which by means of a rivet, a celluloid or gutta-percha plate is firmly attached. The plate itself rests lightly against the temples and being broad and flat, eliminates all undue pressure upon the tender skin of the infant, thereby avoiding both irritation and ulceration, for this reason bows going behind the ears should not be prescribed for

young children, certainly not before their third or fourth year. The metal loop of the bow does not rest firmly against this plate, between both is a space of approximately 1—1½ m.m., through which a ribbon or elastic tape is passed and adjusted as illustrated in plates two, three and four. The tape serves to firmly and comfortably fix the frame and hold it in its proper position. Given a frame of this type, comfortably and properly adjusted, bearing its correcting lenses, a child will almost invariably accept it without any opposition. Curiosity may impell investigation at first, but the little wearer will soon learn to look upon his spectacles as a part of his regular attire and many children, in whom their spectacles serve the additional advantage of giving them clearer and better vision, reach for them with the same sense of devotion as do their presbyopic grand-parents reach for theirs, when they wish to read the mornings news. The child thus equipped with proper

frames and glasses, often nothing more needs be done—the why of this has already been touched upon. If, however, we have to treat a case of more or less long time squint, in which case we may be certain to find the vision of the deviating eye more or less impaired, an attempt to restore such loss of vision should be made. If the visual impairment is not too marked much can be done by occluding the seeing "fixing eye"—so that its deviating fellow may be brought to task. The old method of tieing up the seeing eye, practiced by the old time surgeons, is still in vogue and the best procedure. In its employment, however, we meet as a rule with no small opposition, both on the part of patient and parent, and as this form of treatment in order to yield results, must be persisted in, often for long periods—weeks—and continuously, not merely for daily short or interrupted periods, it can be readily imagined how difficult it is to have this practice carried out. I confess, that in prescribing this treatment I have often met with failure—and have *"nolens volens"*, learned the truth of Longfellow's little proverb—"Patience is a plant that grows not in all gardens," or, as Milton truly says, "Patience is more oft the exercise of saints." Yet with a little ingenuity, a comfortable occluding bandage can be devised and the child brought to wear it with no great opposition, but the children of the day are not all saints and less often so their fond parents, as every physician can readily attest.

Little trouble is met with in this regard if atropine is employed—by means of its use—a drop of a one per cent solution, instilled into the fixing eye once a day—or a salve of the same strength—the power of accommodation, that is the ciliary muscle of the eye is paralyzed—and its vision for near objects impaired, so then the little squinter, in order that he may see his toys or books, must exercise a conjugate movement, such that he brings his squinting eye actively to function. The habit of using his atropised eye for distance, his unatropised for near vision is soon acquired, and in this manner the later, by being thus exercised, is safely guarded against an amblyopia exanopsia. In eyes however, in which an amblyopia already exists, improvement under this form of treatment ensues, commensurate only with the degree of amblyopia and the age of the child. More can be said of the application and theory of these procedures—and in practice, of course, more is done than indicated by these brief outlines, that however, belongs within the confines of special treatise. It should be noted though that, after the sixth year both of the last two methods mentioned are practically useless, in achieving any noteworthy results—allowing perhaps for a few exceptions.

Lastly under non-operative treatment we have to do with the training of the fusion sense, for this purpose various instruments have been devised, a description of which need not concern us here.

Stereoscopes and amblyoscopes, of different forms and types, with numerous modifications for determining the presence or absence of binocular vision and for training the fusion faculty are in use; by means of their employment, much may be accomplished in this direction, especially so with the amblyoscope devised by Worth.

To be of value treatment with it must be inaugurated early. In young children under the age of five years, and in selected cases most favorable results are attained—in ages older than five the results are usually not at all gratifying; in fact

largely failures. The use of these contrivances, in training involves many difficulties with little children and demands much patience, tact and kindliness on the part of the surgeon.

In noting the favorable results that may be obtained by the methods cursorily alluded to above, one luminous fact presents itself, namely, that of the extreme importance of the early recognition and treatment of squint. This is in itself of greater moment, perhaps, than all else in the successful treatment and in the cure of convergent strabismus in children—and its importance cannot be too strongly impressed upon physician and

parent. Secondly though in some cases all efforts at correcting the squint and establishing fusion may fail, prevention of an amblyopia of the squinting eye may be attained—such result unquestionably is of inestimable worth to the possessor of an eye tending to loss of sight from such cause. Again fusion training to be of any material benefit must be taken within the normal period of its development, that is, in the infant and young child. I have dwelt so persistently upon the necessity of early treatment, because then and only then, is success assured in a large portion of cases.

In many cases the powerful desire for fusion thus established directly brings about a sudden cure of the squint. In the larger group of cases, in which optical correction of refractive error is depended upon to lessen and perhaps overcome the deviation, there is no danger of the newly acquired faculty of fusion being lost. If even a faint degree of fusion sense has once been acquired its persistence is truly remarkable.

If all non-surgical measures fail, the question of operation naturally suggests itself. Regarding this the writer has decided opinions. At best the results to be obtained, from operations for convergent strabismus in young children, certainly in the great majority of cases, are an uncertainty —or even failure. I have seen time and again an outward deviation resulting as late as ten, twenty and thirty years after a *"successful"* squint operation. The numerous surgical methods employed and they are many—tenotomy, advancements and puckerings of the muscles, signify too clearly that none have reached a stage of perfection, in so far as assuring a desired and permanent result. The best that can be hoped from a successful squint operation, with few exceptions is to set the eye "straight". Once an eye is amblyopic, its vision lost—I favor waiting until the child has reached a mature age before operating. No operation will restore sight. Opinions differ widely as to when and how to operate. I do not hesitate to caution against early operations as a routine measure in young children, for the correction of strabismus convergence, and if deemed necessary, then only as a measure of very last resort, after all non-surgical measures have been given a most painstaking and thorough trial.

CHAIRS AT A PREMIUM.

The question, "Do soldiers like to read?" was answered in a letter written by the American Library Association's representative at Camp Jackson.

"There is one continual rush from 5:45 A. M. till 11:30 or so at night," he writes. "The new commanding general dropped in today and suggested that we add a front porch to be used as a summer reading room."

The situation is as interesting at Camp Greene. The librarian at Camp Greene writes: "Last Thursday there were 320 men in here looking for books at 7 o'clock. I guess we handled a thousand men that night. There were 53 sitting on the floor reading at one time."

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EDITORIALS

LEST YOU FORGET.

THIS ISSUE CLOSES THE FISCAL YEAR OF THE JOURNAL AND YOUR SUBSCRIPTION ENDS. IN A FEW DAYS YOUR MEMBERSHIP IN YOUR STATE MEDICAL SOCIETY AND YOUR PROTECTION UNDER ITS MEDICAL DEFENSE CLAUSE WILL EXPIRE. EACH YEAR YOUR OVERWORKED AND UNDER-PAID COUNTY SECRETARY HAS BEEN COMPELLED TO WRITE AGAIN AND AGAIN TO MEMBERS FOR THEIR DUES. LETS EASE UP ON HIM THIS YEAR. YOUR 1919 DUES ARE PAYABLE *NOW!* MAKE HIM A XMAS PRESENT THIS YEAR BY SENDING THEM *TODAY!*

THE DUTY OF THE MEDICAL PROFESSION IN THE RECONSTRUCTION OF THE WAR CRIPPLE.

WE must count on the return from the front of thousands of crippled soldiers. We must plan to give them the best possible chance for the future.

The government will provide the best of surgical care and special training for self-support. But whether this really puts the disabled man back on his feet in the community depends on whether the attitude of the public operates as a help or hindrance.

The American Red Cross desires to enlist the assistance of members of the medical profession—in their joint rôles of personal advisers and leaders of community opinion—in promoting sound doctrine on these four points:

1. To convince the public that the cripple is not helpless but capable of being restored to complete independence if trained and placed in the right line of work.

2. That it is no kindness to encourage the cripple to idleness; but on the contrary every influence should be brought to bear to have him accept training and prepare for useful employment.

3. That the duty of the community is intelligently to employ him, rather than to expend equivalent energy in social entertainment or in the expression of unwise sympathy which tends more to demoralize than to build up character.

4. To make known to the public in general, and to the families of soldiers in particular, the remarkable results in the reconstruction of crippled men being attained by modern methods of medical and social science. The greatest terror in war has been the prospect of returning home disabled. It is no more than fair that mothers should know how little the loss of a limb means now to the man who is himself determined to succeed.

The thoughtful consideration of this subject by the medical profession of the United States will constitute a real service to the future of the crippled soldier.

NAILING THE LIE.

IT must ever be so that when men are sick away from home in large hospitals, there are some who kick and complain about the treatment they receive. Sometimes it is not the man himself who makes the complaint, often he is perfectly satisfied, but some interfering relative who feels that his or her Johnny or Jimmy is not getting all the attention that Johnny or Jimmy should have.

During the epidemic of measles and pneumonia last year it may be remembered that so many charges were brought against the ill treatment of patients in the cantonment hospitals that Congress instituted an investigation and certain Medical officers were reprimanded for neglect of duty. We who have been in the work for many years know full well that no patient is ever neglected to the extent to which hysterical friends and relatives are inclined to say that they are neglected.

It has come to our knowledge that in certain parts of Wisconsin rumors are being circulated to the effect that at a certain army hospital, men about to die were wrapped in a sheet and placed on the floor where they would be out of the way. Anyone hearing such a statement as this and not characterizing it as a damnable lie shows a lack of appreciation of all the sacrifices that the civilian Medical profession has made in this world conflict. It is inconceivable to our minds that anyone should start such a baseless and lying rumor as this. From personal knowledge we know that the treatment of patients at the hospital where this condition of affairs noted above, as a rumor, is said to exist, was as good if not better than the treatment given patients in any civilian hospital at the present time. As a matter of fact the army has most of the nurses and most of the doctors, and plenty of other help to take care of the sick men; and furthermore, this particular hospital has received high praise from all sides for the manner in which the Medical officers, nurses and enlisted personnel handled the patients during this last epidemic of influenza and complicating pneumonia.

We have no hesitancy in saying to the Medical profession throughout the state that we urge them to use their influence in promptly squelching such baseless and pro-German rumors. We can assure them that they can catagorically deny all rumors of ill treatment of soldiers at any army hospital. We therefore look to the Medical profession of the state to stand behind the Medical profession in the army, and nip in the bud all such lying rumors.

L. M. W.

AESCULAPIUS LAUGHS.

DURING the height of the influenza epidemic, many children, and I suppose adults as well, if the truth were known, wore the old fashioned camphor bags and camphor balls as a preventive of the disease. One of these, unless my informant was mistaken, was a member of a physician's family. Thus intelligence once more gave way to superstition in the face of a great fear.

Similarly, devotees of a religion which holds disease to be the result of fear forsook their religion, outdid the infidels, and added to the burdens of the medical profession. At the same time, costly advertisements were published in the newspapers by the priests of cult, denouncing the health department's regulatory measures designed to lessen the danger of overcrowding and passage of germs directly from mouths of hosts to mouths of victims.

Coincidentally, every health officer who is not a simpering idiot was seared too. Even some who hold enviable reputations as health officers joined the "For God-Sakers." Possibly everybody does not know that the Forgodsakers are a great cult who in times of stress lose their poise, whirl around and around in excentric circles and cry, "For God's sake, *do* something."

It was even suggested that some great scientists who were supposed to be firmly established on strong foundations went off their base, also.—And old Father Aesculapius laughed, dug the spirit of Hypocrates in the ribs and said: "What fools these mortals be."—*H. E. D.*

"SHELL SHOCK."

A CIRCULAR issued by the Surgeon General regarding Sick and Wounded Reports warns medical officers that the term "Shell Shock" will no longer be accepted as a diagnosis of disability or death. It is high time that civilian physicians as well as medical officers in the army come to a realization of the importance of suggestion. Preventable disease is not all of bac-

terial origin and much of our sick wastage is due to infected thoughts and careless words. Many a good soldier has been lost to the front lines because a thoughtless officer has used the term "Shell Shock" on a diagnosis or field medical card. Many a good soldier in the great work of civil life has been lost through a careless remark made to the patient by those whom they rightly regard as authorities in medical matters.

It is our duty to try to prevent nervous and mental disease as well as infectious and there is as little excuse for suggesting permanent or semi-permanent nervous invalidism to a patient as for the field officer to suggest a functional nervous disease to the soldier from the front.

The control of war neuroses is one of the great new medical problems and those of us at home will soon be called upon to help meet this problem. Those directly responsible at this time are making every effort to minimize these disorders in the A. E. F. They will need the help of every civilian physician when these boys come home. Do not use the term "Shell Shock" yourself or permit those associated with you in the care of these people to use it. It is not a medical term but a piece of military slang. To discontinue using it shows a desire to preserve man-power, to be accurate and clear in medical nomenclature and to follow the advice of those in charge and expressed in regulations framed after thoughtful consideration; to continue using it shows clinical slovenliness, disregard for regulations and indifference to preventable wastage of man-power.

MEDICAL MOBILIZATION AND THE WAR

COMMISSIONING OF PHYSICIANS AND ALL PROMOTIONS STOPPED.

The Surgeon-General's Office advises that since 10 o'clock of the morning of November 11, the War Department discontinued the commissioning of officers in the various corps of the Army, including physicians in the Medical Corps. This condition, it is stated, is in all probability permanent and favorable consideration will not be given to applications for commissions in the Medical Corps until further notice. At the same time favorable considerations on the recommendations for the promotion of officers was discontinued and no further promotions will be made until this embargo is modified.

DEMOBILIZATION OF THE ARMY.

In a press interview given by the Secretary of War, Nov. 15, 1918, it was stated that the first units to be demobilized will be the Development Battalions at the camps. These battalions are made up of men who are under physical requirements, or undergoing special drill or discipline to bring them into military value.

Every man who is discharged from the Army must have a complete physical examination for permanent record. This is the great task which now devolves on the Medical Department.

In an interview by Gen. Peyton March, November 16th, it was stated that some 200,000 men will be mustered out within two weeks and then when the machine is in operation, some 30,000 men will be released daily. General March stated that under the present laws, every man who is discharged is entitled to wear his uniform for a period of three months.

Officers will be listed into various groups: those who wish to apply for commissions in the Regular Army; those who wish to put themselves into a class where they can be used for future military operations will be offered commissions in the Reserve Corps; all others will be given honorable discharges. General March stated that he had issued an order to all the staff corps stating that the discharge of officers and men must keep pace with cutting down of the work, and each department has been directed to submit a list of officers and men from time to time as they can be spared for discharge.

HONORS TO MAJOR-GEN. WILLIAM C. GORGAS.

Major-Gen. William C. Gorgas has been notified that the decoration of "the Grand Officer of the Order of the Crown of Italy" has recently been conferred on him.

On October 26, Secretary of War Baker wrote the following letter to General Gorgas:

October 28, 1918.

My Dear General Gorgas:

Your official term as Surgeon-General of the Army having expired. I beg leave to express to you the appreciation of the Army and the country of the distinguished services which you have rendered during your long and brilliant career as a medical officer. Even the gracious modesty which is a part of your habit of thought cannot keep you from realizing that your career has been one of brilliant distinction, and that the Medical Department of the Army has profited from your services, as it has been honored by your deservedly high reputation. The operation of law has terminated your period of active service, except for the emergency work which you are

now doing under my direction, but it will be a source of satisfaction to me and a comfort to the people of the country to realize that your interest will continue in the Army and in the great scientific researches in which your life has been engaged.

If I may add a personal word to this note, I beg you to accept my grateful acknowledgment of the cordial and helpful relations which have existed between us officially, and to thank you for the many personal courtesies and kindnesses which I have received from you during our most happy association.

I am placing a copy of this letter in the hands of the Adjutant General in order that it may become a part of your record in the department, and may there remain as an evidence of the complete success with which you as a soldier and a doctor have through long years and under varying and difficult conditions served your country.

Cordially yours,

NEWTON D. BAKER,
Secretary of War.

PERSONNEL OF THE MEDICAL DEPARTMENT.

On November 22 the total commissioned personnel of the Medical Corps was 31,158, a decrease of 240 from the previous week, consisting of 3 major-generals, 7 brigadier-generals, 187 colonels, 431 lieutenant-colonels, 2,338 majors, 9,807 captains and 18,385 first lieutenants. The total number in active service was 30,339, a decrease from the previous week of 252. To date 2,791 officers have been discharged for the following causes: physical disability, 1,006; inaptitude, 333; other branches of service, 727; resignations, 305, domestic troubles, 64; needed by community, 50; deaths, 261; dismissals, 24; duty completed, 3; no reasons given, 18.

RESOLUTION TO PROVIDE A RESERVE CORPS FOR THE PUBLIC HEALTH SERVICE.

A joint resolution to provide a reserve corps for the United States Public Health Service was approved by the President October 27. The resolution states:

Resolved, By the Senate and House of Representatives of the United States of America in Congress assembled, That for the purpose of securing a reserve for duty in the Public Health Service in time of national emergency there shall be organized, under the direction of the Secretary of the Treasury, under such rules and regulations as the President shall prescribe, a reserve of the Public Health Service. The President alone shall be authorized to appoint and commission as officers in the said reserve such citizens as, upon examination prescribed by the President, shall be found physically, mentally, and morally qualified to hold such commissions, and said commissions shall be in force for a period of five years, unless sooner terminated in the discretion of the President, but commission in said reserve shall not exempt the holder from military or naval service.

Provided, That the officers commissioned under this act, none of whom shall have rank above that of Assistant Surgeon-General, shall be distributed in the several grades in the same proportion as now obtains among the commissioned medical officers of the United States Public Health Service and shall at all times be subject to call to active duty by the Surgeon General, and when on such active duty shall receive the same pay and allowances as are now provided by law and regulation for the commissioned medical officers in the said regular commissioned Medical Corps.

BUREAU OF MEDICAL RESEARCH AND INTELLIGENCE FOR RED CROSS IN PARIS.

Among its other activities the American Red Cross in France has established a Bureau of Medical Research and Intelligence Department, of which Lieut.-Col. Alexander S. Lambert is the chief. The individual divisions are: Medical Library, Medical Publications, Medical Research and Medical Intelligence bureaus. The department undertakes to supply the field, camp and evacuation hospitals with medical books and journals as also to reply to individual requests as to most recent developments in war medicine and surgery. For the latter, the Medical Intelligence Bureau, of which Major Thomas H. Halsted is chief, is occupied specially with looking up literature, reports of commissions, etc. It responds at once to all requests for information on medical and allied subjects asked for by any medical member of the American Expeditionary Forces or of the Red Cross. An index is kept of all articles relating to war medicine and surgery, and also abstracts of the more important ones. Dr. Emil Mayer of New York City has been appointed representative of the United States for this bureau. Writers of original articles on war subjects are requested to send two reprints thereof as soon as possible to the Medical Intelligence Bureau, American Red Cross, 9 rue du Mont Thabour, Paris, France.

MEDICAL VETERANS OF THE WORLD'S WAR.

There has been incorporated in the District of Columbia an organization to be known as the Medical Veterans of the World's War, and on Nov. 15, 1918, the following was recorded:

CERTIFICATE OF INCORPORATION.

KNOW ALL MEN BY THESE PRESENTS, THAT WE, the undersigned, all of whom are citizens of the United States, and a majority of whom are residents of the District of Columbia, desiring to associate ourselves together to form an association under the provisions of the Code of Law for the District of Columbia, enacted by Congress and approved by the President of the United States, hereby certify that,

First: The name of the association shall be Medical Veterans of the World War.

Second: The term for which it is organized shall be perpetual.

Third: The particular business, objects and purpose of the association are: To perpetuate fellowship, prepare history, secure co-operation for the mutual benefit of the medical men who served in the War of Nations, 1914-1918, and for the mutual improvement and social intercourse of its members.

Fourth: The number of trustees who shall manage the affairs of the association for the first year of its existence, and until otherwise provided, shall be seven, who shall be the incorporators named below; and nothing herein contained shall prevent the association in increasing the number of trustees for any subsequent year of its existence.

In witness whereof we, Frederick F. Russell, Edward R. Stitt, James C. Perry, James S. Easby-Smith, Victor C. Vaughan, William J. Mayo and Hubert Work, have hereunto subscribed our names and affixed our seals this fifteenth of November, A. D. 1918.

Frederick F. Russell,
Edward R. Stitt,
James C. Perry,
James S. Easby-Smith,
Victor C. Vaughan,
William J. Mayo,
Hubert Work.

District of Columbia, ss:

I, N. Curtis Lammond, a Notary Public in and for the district aforesaid, do hereby certify that Frederick F. Russell, Edward R. Stitt, James C. Perry, James S. Easby-Smith, Victor C. Vaughan, William J. Mayo and Hubert Work, parties to a certain certificate of incorporation bearing date on the 15th day of November, A. D. 1918, and hereto annexed, personally appeared before me, in the district aforesaid, the said Frederick F. Russell, Edward R. Stitt, James C. Perry, James S. Easby-Smith, Victor C. Vaughan, William J. Mayo and Hubert Work, being personally well known to me to be the persons who executed the said certificate, and acknowledged the same to be their act and deed for the purposes therein named.

Given under my hand and notary seal this 15th day of November, A. D. 1918.

N. Curtis Lammond,
Notary Public.

The several federal departments and civilian organizations co-operating in the formation of this new association are as follows:

INCORPORATORS.

Colonel Frederick F. Russell, representing The Surgeon-General of the Army.

Rear Admiral Edward R. Stitt, representing The Surgeon-General of the Navy.

Asst. Surg.-Gen. James C. Perry, representing The Surg.-Gen. of Public Health Service.

Colonel James S. Easby-Smith, representing The Provost Marshal General.

Colonel Victor C. Vaughan, representing The Association of Military Surgeons.

Colonel William J. Mayo, representing The American College of Surgeons.

Lieut.-Col. Hubert Work, representing The American Medical Association.

It is proposed that the membership of the Medical Veterans of the World's War shall include (a) all medical officers who have served in the Medical Corps of the U. S. Army, the U. S. Navy, and the U. S. Public Health Service; (b) all physicians who have been officially appointed by the President, Provost Marshal-General, or the governors of states, and who have served as members of or medical examiners on Local, Medical Advisory and District Boards.

A temporary organization has been effected, and a committee appointed to draft a constitution and by-laws.

Hubert Work, *President,*
Frederick F. Russell, *Secretary,*

Officers of the temporary organization.

WAR NOTES

Word has been received that Capt. E. G. Eck of Lake Mills, in service abroad, has been gassed.

Dr. T. C. Clark of Oconto, in service in France, has been promoted to Captain.

Major J. R. Scott, now in France, has been promoted from Sanitary Inspector of the 64th Brigade to Division Surgeon of the 32nd Division. He succeeds Colonel Gilbert Seaman of Milwaukee, who established a record which has been recognized by placing him as Corps Surgeon for the 6th Corps.

Lieut. W. J. Fleming, stationed at Camp Gordon, has been promoted to the rank of Captain.

Dr. Eugene Gates of Two Rivers, stationed in Paris, France, has been promoted to a Majority.

Capt. F. A. Thompson, with Base Hospital No. 22, has been promoted to the rank of Major.

Capt. Victor F. Marshall, assigned to Evacuation Hospital No. 46, Camp Greenleaf, Georgia, visited his home on a brief furlough the first week of November.

Lieut. G. L. Bellis, formerly Supt. of Muirdale Sanatorium, who has been in France for something over a year, has been promoted to the rank of Major.

Capt. W. A. Ladwig of Wausau has been granted a leave of absence by the Board of Trustees of the County Home and Hospital.

Capt. J. B. Spalding, former Health Commissioner of Kenosha, recently visited in Kenosha on leave of absence.

Lieut. J. H. Fowler of Fennimore has been promoted to the rank of Captain.

Lieut. G. C. Waufle, of Janesville, has cabled his wife that he has reached France safely, and has been assigned to Base Hospital No. 98.

Mrs. E. R. Murphy of Antigo has received a letter from her husband, Capt. E. R. Murphy, stating that he has been promoted to Captain, and assigned to Base Hospital No. 78.

Maj. Gen. William Gorgas, former surgeon general of the army, will be returned to the retired list on Dec. 1, the war department announced. When he reached the age of retirement several weeks ago, Gen. Gorgas was recalled to active duty to make a special investigation into matters pertaining to the health of the army and his report now is before Secretary Baker.

Capt. S. M. B. Smith, of Wausau, who gave up his practice of medicine in Wausau a year ago to engage in Red Cross work overseas, is home again after serving as medical director in a dispensary hospital for refugees at St. Etiennes, France. Capt. Smith left France Oct. 30, and arrived in New York in time to join the peace celebration Monday.

Lieut. I. B. Pippin, formerly of Excelsior, from which village he enlisted in Uncle Sam's Medical Corps, is home because of injuries he received on the front in France. He was injured some weeks since by a piece of shrapnell and was sent home for recuperation and a possible further operation. It will probably be several months before the lieutenant will be in shape for further army duties.

Because of the departure for camp of Drs. Leander J. Foley, Twentieth Street, and Gerald T. Savage, Seventeenth Street, who had charge of the Industrial Emergency Hospital at Nineteenth and Clybourn Streets, Milwaukee, the hospital has been closed.

Capt. A. J. McCarey, a Green Bay physician with the Fourth Division, has been appointed director of ambulance companies to fill a vacancy caused by illness, and he is now assistant to the divisional surgeon of the Fourth Army.

ORDERS TO OFFICERS OF THE MEDICAL CORPS, U. S. ARMY.

To Camp Crane, Pa., Evacuation Ambulance Company, from Fort Riley, Capt. E. A. Ketterer, Montford.

To Newport News, Va., from Fort Oglethorpe, Lieut. W. J. Murphy, Milwaukee.

Honorably discharged, Lieut. M. A. Froney, Racine. On account of physical disability existing prior to entrance into the service, Capt. A. M. Foster, Racine.

To Camp Crane, Pa., evacuation ambulance company, from Fort Riley, Capt. M. E. Rideout, Hortonville.

To Washington, D. C., Surgeon-General's Office, from Camp Custer, Capt. B. H. Holmes, Delavan.

To Camp Crane, Pa., evacuation hospital, from Camp Grant, Capt. P. A. Fox, Milwaukee.

To Camp Jackson, S. C., base hospital, from New Haven, Lieut. U. J. Durner, Milwaukee.

To Camp Zachary Taylor, Ky., base hospital, from New York, Lieut. W. C. Darling, Milwaukee.

To Carlisle, Pa., from Camp Crane, W. Hecker, Beloit.

To Detroit, Mich., from Camp Custer, Lieut. S. J. Seeger, Milwaukee.

To New York, Bellevue Hospital, for instruction, and on completion to his proper station, from Camp Sherman, Lieut. W. J. Winnemann, Athens.

To San Antonio, Texas, as tuberculosis examiner, from Camp Dodge, Capt. C. H. Meyst, Burlington.

To Washington, D. C., from Camp Meade, Major J. R. McDill, Milwaukee.

To Willoughby, Ohio, from Fort Oglethorpe, Lieut. R. M. Campbell, Milwaukee.

The following order has been revoked: To Camp Gordon, Ga., base hospital, from Army Medical School, Capt. F. A. McJunkin, Milwaukee.

To Boston, Mass., from Camp Custer, Lieut. J. M. Mecum, Bagley.

To Camp Crane, Pa., base hospital, from Camp Dodge, Capt. E. L. Mason, Eau Claire; from Edgewood, Md., Lieut. W. P. Miller, Milwaukee. Mobile hospital, from New Haven, Lieut. O. E. Ishmael, Mount Horeb.

To Camp Custer, Mich., base hospital, for instruction, from Fort Sheridan, Lieut. T. W. Nuzum, Janesville.

To Camp Fremont, Calif., as assistant to camp surgeon, from Camp MacArthur, Capt. C. M. Meyer, Milladore.

To Camp Joseph E. Johnston, Fla., base hospital, from Camp Jackson, Capt. S. G. Pake, Hayward.

To Camp Shelby, Miss., base hospital, from Camp Custer, Lieut. R. E. Flynn, La Crosse.

To Fairfield, Ohio, Wilbur Wright Field, from Mount Clemens, Capt. E. G. Festerling, Reedsville.

To Garden City, N. Y., from Americus, Ga., Capt. C. J. Rollefson, Superior.

To San Antonio, Texas, Brooks Field, from San Diego, Capt. F. W. Pope, Racine.

COMMISSIONS OFFERED AND ORDERS TO DUTY ON ACCEPTANCE.

To Camp Custer, Mich., Lieut. E. R. Deboth, Green Bay. Base hospital, for instruction, Lieut. I. E. Levitas, Green Bay. To examine the command for nervous and mental diseases, Capt. W. T. Kradwell, Wauwatosa.

To Camp Grant, Ill., for instruction, Capt. F. A. Forsheck, Milwaukee.

To Fort Oglethorpe for instruction, Lieuts. H. P. Brown, Johnson Creek; R. E. Fitzgerald, M. L. Nahin, Milwaukee; E. S. Ryan, Sheboygan.

To Fort Riley for instruction, Lieuts. J. M. Kelley, Cato; E. Charbonneau, W. E. Hatch, Superior.

To Camp Grant, Ill., base hospital, Capt. W. A. Smith, Boyd.

To Fort Oglethorpe for instruction, Capt. R. J. Gogglns, Oconto Falls; Lieuts. I. G. Davis, Arcadia; W. M. Johnston, Dale; R. C. Pynn, Delavan; F. C. Fischer, Milwaukee; A. J. Loughnan, Oconomowoc; M. M. Bunch, Oshkosh; W. J. Hommel, Whitewater.

To Fort Riley, as tuberculosis examiner, Capt. J. W. Lockhart, Oshkosh. For instruction, Lieuts, R. D. Jamieson, La Crosse; G. E. Forkin, Menasha; W. E. Fox, W. G. Hyde, Milwaukee; L. C. Combacker, Osceda.

To New Haven, Conn., Yale Army Laboratory School, for instruction, Major G. C. Ruhland, Milwaukee.

To Camp Grant, Ill., base hospital, for instruction, Lieut. B. C. Tarnutzer, Beaver Dam.

To Camp Pike, Ark., Lieut. H. C. Stoltz, Milwaukee.

To Camp Sherman, Ohio, base hospital, Capt. A. G. Hough, Madison.

To Fort Oglethorpe for instruction, Lieut. A. J. Williams, Waukesha.

To Fort Riley for instruction, Capt. M. E. Rideout, Hortonville; Lieuts. A. C. Edwards, Arcadia; M. P. Andrews, Beloit; F. Babcock, Cumberland; J. L. Bender, Ithaca; O. H. Anderson, Plum City; C. M. Anderson, Wild Rose.

To report to the commanding general, Central Department, Lieut. J. W. Tarter, Iron River.

MIXES HERRICK AND HENTY.

Out at Camp Grant there is a youthful soldier who knows just what books are for.

"I want something by Herrick to make me sore, and something by Henty to wash the taste out of my mouth," he said, as he leaned up against the desk of the American Library Association's camp library.

"Does Herrick depress you?" asked T. R. Temple, the camp librarian.

"Listen to me," said the young soldier. "That fellow Herrick never wrote a line in his life until he got all het up over something."

THE STATE MEDICAL SOCIETY OF WISCONSIN

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The Wisconsin Medical Journal, Official Publication

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Calumet	W. C. Schmitz, School Hill	F. P. Knauf, Kiel.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	L. H. Prince, Madison	W. H. Sheldon, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	H. E. Twohig, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	R. E. Flynn, La Crosse	Jens Rosholt, La Crosse.
La Fayette	J. C. Huhenthal, Belmont	H. O. Schockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	J. E. Meany, Manitowoc.
Marathon	W. E. Zilisch, Wausau	F. H. Frey, Wausau.
Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. H. Fellman, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	A. R. Bell, Tomah	S. D. Beebe, Sparta.
Oconto	C. W. Stoelting, Oconto	Minnie Hopkins, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	E. R. Boyer, Rhinelander.
Outagamie	J. J. Laird, Black Creek	M. J. Sandhorn, Appleton.
Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
Pierce	W. A. Lumley, Ellsworth	Rollo Cairns, River Falls.
Portage	D. N. Alcorn, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	G. C. Wichman, Rib Lake.
Racine	G. W. Nott, Racine	Susan Jones, Racine.
Richland	R. H. Delap, Richland Center	G. Benson, Richland Center.
Rock	M. P. Andrews, Beloit	E. B. Brown, Beloit.
Rusk	J. C. Baker, Hawkins	L. M. Lundmark, Ladysmith.
Sauk	F. D. Hulburt, Reedsburg	Roger Cahoon, Baraboo.
Shawano	J. B. Gordon, Shawano	W. H. Cantwell, Shawano.
Sheboygan	H. C. Reich, Sheboygan	T. J. Gunther, Sheboygan.
St. Croix	B. Kunny, Baldwin	O. H. Epley, New Richmond.
Trempealeau-Jackson-Buffalo	Wm. Belitz, Cochrane	C. F. Peterson, Independence.
Vernon	J. K. Schreiner, Westby	F. E. Morley, Viroqua.
Walworth	M. D. Cottingham, Lake Geneva	E. Kinne, Elkhorn.
Washington	H. F. Weber, Newburg	A. H. Heidner, West Bend.
Waukesha	G. E. Peterson, Waukesha	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	J. W. Lockhart, Oshkosh	E. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Ruckle, Grand Rapids.

SOCIETY PROCEEDINGS

OUTAGAMIE COUNTY.

Dr. O. W. McMichael, an international medical authority on tuberculosis, appeared before the Outagamie County Medical Association in one of its most successful meetings, held October 15 at the Y. M. C. A. He led a discussion on the talk of Dr. Robert R. Hays of Chicago, on "Early Clinical Diagnosis of Pulmonary Tuberculosis." Dr. McMichael is proprietor of the Winyah Sanitarium at Ashville, N. C., and is on a tour of the country training camps giving talks to army examiners.

Other talks were given by Dr. I. S. Trostler of Chicago. on Roentgenology as an Aid to Gastro-Intestinal Diseases, and Dr. Robert R. Hays of Chicago, as mentioned above. The addresses of Dr. Trostler and Dr. McMichael were illustrated with lantern slides.

The meeting was one of the most successful held by the society in recent years. It was attended by more than forty physicians from Appleton, Neenah, Oshkosh and other neighboring cities. Supper was held at 6:30 o'clock, followed by the addresses of the evening. Similar meetings are held monthly.

M. J. Sandborn, M. D., *Secretary.*

MILWAUKEE COUNTY.

The regular meeting of the society was held at the Hotel Wisconsin, on Friday evening, November 8th, at 8:30 o'clock. The following program was presented: "The Overtreatment of Neurosyphilis," by Dr. D. W. Roberts. The rest of the meeting was devoted to the reporting of clinical cases.

Daniel Hopkinson, M. D., *Secretary.*

CORRESPONDENCE

November 13, 1918.

From: Mr. Charles H. Conner, Chief, Platinum Section, and
Lieut. Col. F. F. Simpson, M. C., U. S. A., Chief of Section of Medical Industry.

To: The Doctors and Dentists of the Country.

Subject: Cancellation of Appeal for the Collection of Scrap Platinum.

1. The Platinum Section and the Section of Medical Industry, War Industries Board, desire to express appreciation of the hearty response made by physicians, dentists and others when the call for scrap Platinum was made.

2. As the Governmental demand for Platinum in the making of explosives, etc., has been tremendously decreased by the curtailed war program, it is requested that no further scrap Platinum be tendered to the Government through the channels indicated in our communication of September 17th, 1918.

C. H. Connor,
Chief, Platinum Section.
Lieut. Col. F. F. Simpson, M. C., U. S. A.,
Chief of Section of Medical Industry.

Milwaukee, Wisconsin,
October 4, 1918.

Surgeon General Ireland,
Surgeon General's Office.
Washington, D. C.

The Wisconsin State Medical Society, in session at Milwaukee, October 4, 1918, extends its congratulation to General Ireland upon his appointment as Surgeon General of the United States Army, and assures him of the hearty co-operation and support of the members of the Wisconsin State Medical Society.

Charles H. Lemon,
D. J. Hayes,
L. F. Jermain,
Committte.

November 2, 1918.

Charles H. Lemon, M. D.,
Milwaukee, Wisconsin.

My dear Dr. Lemon:

I desire to assure you of my appreciation of the congratulations extended to me by the Medical Society of Milwaukee upon my appointment as Surgeon General of the Army.

It is a source of inspiration to know that I have the co-operation and support of the splendid body of men representing the profession in your State.

With cordial regards, believe me,

Very sincerely yours,

Merritte W. Ireland,
Major General, Medical Corps, Surgeon General, U. S. Army.

DEMOBILIZATION.

Physicians in the service and those at home who are carrying their work are now most interested in the subject of demobilization. In reply to a letter of inquiry the following has been received from the Surgeon General's office.

From: The Surgeon General.

To: Maj. Rock Sleyster, M. C., U. S. A., Waupun, Wisconsin.

Subject: Medical Corps.

1. I am directed by the Surgeon General to acknowledge the receipt of your letter of November 18th, and to advise you that this office would scarcely be in a position to use the information which would be conveyed in connection with the officers now on active duty who are needed in their communities.

2. The War Department has adopted a definite plan of demobilization of officers of the Medical Corps and this demobilization will be affected as expeditiously as possible. Officers who are needed in their communities should present that information to the Commanding General of the command to which they are attached and it will be given due consideration in connection with the elimination of such physicians from the service. The process of demobilization will be executed as rapidly as possible, and the physicians will be returned home as expeditiously as the military conditions will permit.

BERT W. CALDWELL,
Colonel, Medical Corps, U. S. Army.

NEWS ITEMS AND PERSONALS.

Dr. W. L. Thompson, of Sheboygan, arrived home November 11th, after having spent a month at Standish, New York, in the United States Public Health Service.

Mayon Hoan of Milwaukee has vetoed the Council's resolution, granting Major G. C. Ruhland, Health Commissioner, a leave of absence to enter the Service.

The offices of Drs. Geo. A. Ribeneck and Roy E. Mitchell of Eau Claire were burglarized Nov. 7th, the thieves taking only their supply of morphine and cocaine.

Dr. C. R. Bechmann of La Crosse has retired from practice and will take an extended vacation after 21 years of continuous practice at his present location.

Dr. H. L. Sarvella of Superior has been appointed Company Physician for the Superior Shipbuilding Company.

Dr. C. H. Lemon of Milwaukee was elected Chief Veteran of the Veterans' Association of the T. M. E. R. & L. Company of Milwaukee at the Annual Meeting of the Association November 16th.

Maj. George C. Ruhland, health commissioner of Milwaukee, has received a message from R. Leigh of the United States public health service, who attended the conference, advising that, in view of the return of men in the service, there be no relaxation on the vice control maintained during the war. Maj. Ruhland said it is a timely suggestion. He desires a downtown clinic for the treatment of social diseases and will confer with the county board of supervisors relative to the establishment of one with the $30,000 appropriated for the fight on the influenza epidemic, which money was not all used because the city also had made a large appropriation. The city and county governments, he believed, should unite forces for the regulation of social conditions, pertaining to the soldier's return.

Recommendations that the Milwaukee city health department be re-organized into three distinct bureaus will be made to the common council by the finance committee. It is proposed that bureaus of child hygiene, contagious diseases and tuberculosis be created. Under the bureau of child hygiene would be the divisions of child welfare and school hygiene. Under the contagious disease bureau would be placed the divisions of bacteriology and hospitals. The tuberculosis bureau would have under its supervision of the Blue Mound Sanitorium, the Preventatorium and the division of clinics. The divisions of food inspection, sanitary inspection and the chemical laboratories would be operated as at present.

Dr. D. B. Rice, for a number of years a successful practicing physician at Fayette, has gone to St. Paul to take up work in the service of the United States Government. His wife and son will make their home in Kentucky until the war is over.

William Black, of Milwaukee, arrested by Special Investigator Dorsch, of the district attorney's office, charged with practicing medicine without a license, was arraigned in district court and his case continued to Nov. 14. The original bail of $1,000 remained unchanged.

The La Crosse county board of supervisors voted down the proposition of the La Crosse County Medical Society to take over the duties of county physician and divide the work among all doctors. Dr. R. H. Herbert was reelected county physician for one year.

Dean Henry L. Banzhaf of Marquette University attended a conference at Washington Nov. 17 of the committee on education and special training of the war department. The committee considered ways and means to harmonize the military courses with studies in medicine, dentistry and veterinary surgery.

Dr. Charles Gorst, formerly superintendent of Mendota Hospital, is located in Mobile, Alabama, as director of health and sanitation for the Mobile Shipbuilding Co.

Dr. J. P. Lenfestey, health officer of De Pere, was elected county physician by the county board which held its fall meeting last week. Dr. Lenfestey takes the place of Dr. F. L. Crikelair, who is going overseas.

DEATHS

Dr. Nathan Kendall Mills of Odanah, a graduate of St. Louis University School of Medicine, 1911, died at the Ashland General Hospital, of influenze, Nov. 10th. Dr. Mills was formerly located at Ashland, and had been at Odanah since last May, when he succeeded Dr. Sincock, who enlisted in the Medical Corps of the Army. He was a member of the State Medical Society and of the American Medical Association.

Dr. H. J. Wall of Richland Center died at the home of his daughter in Milwaukee, Nov. 14th. Dr. Wall was

born in Ithaca, New York, July, 1844, and was educated in Ithaca, the Washington Academy, and at Geneva College. In 1879 he entered Rush Medical College. In the fall of 1863 he enlisted in the 21st New York Cavalry, and was active in raising the full quota of the regiment, which was mustered in at Elmira, New York. He served during the remainder of the War under Gen. Siegel and Gen. Sheridan. After the War he practiced medicine for a time at St. Paul, and located at Richland Center in 1875, where he has since resided. He was a member of the State Medical Society and of the American Medical Association.

Lieut. Franklin M. Hawley of Mercer, Wis., died Oct. 4th of spinal meningitis in an Army Hospital in France. Dr. Hawley was on duty in a large hospital in France at the time of his death, and when taken sick refused to stay in bed, and went about providing comfort for his patients until the last. He was located at Mercer, Wisconsin, at th time he enlisted, but had previously practiced at Bayfield. Dr. Hawley was born in 1863, and was a graduate of Drake University College of Medicine, Class of 1883.

Dr. Francis De Sales Dube, of Centuria, died Oct. 22nd, of influenza. He was born in Montreal, but came to the United States at an early age with his parents. He was a graduate of Marquette University Medical School, Class of 1908, and formerly practiced in Milwaukee. He is survived by his father, F. C. Dube of Escanaba, Michigan, a widow and a brother and sister. He was a Fellow of the American Medical Association and a member of the State Medical Society. He held a commission as Lieutenant in the Medical Corps, and was awaiting orders at the time of his death.

Dr. Robert G. Marriner, for 37 years a practicing physician in Marinette and Menomonie, died Nov. 21st of pneumonia. He was born in London, England, Dec. 5, 1857, and removed to the United States in 1867. He graduated from the Chicago Medical College in 1881, and practiced in Marinette until 1888, when he moved to Menomonie.

Dr. Sebastian Keller, for many years a resident of West Bend, died in Spokane, Washington, Nov. 3rd. He was born in Bavaria, Germany, 1830, received his medical education at Wuerzburg, and came to the United States in 1855. He practiced at West Bend until 1898, when he left for Spokane. His remains were brought to West Bend for interment.

MARRIAGES

Dr. L. H. Graner and Miss Josephine M. Slaton were married at Pound, Wis., August 7, 1918. They are now located at Coleman, Wis.

Many of our poorer citizens are undergoing real sacrifices that they may be able to show their patriotism by buying War Savings Stamps.

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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VACCINES AND SERA.

A vaccine is a substance which when properly administered stimulates the body cells to resist infectious matter. The resistance is specific. That is to say that a vaccine made of typhoid bacilli produces resistance to typhoid bacilli only and is protection against typhoid fever only. Vaccination with smallpox virus protects against smallpox only. The protection is obtained by producing a condition, which is similar to the disease against which the vaccine is a protection. The condition similates the actual disease but in much milder form. It does not leave any harmful results. The form of resistance thus established is called active immunity because it results from actual reaction on the part of the body cells. It stands in contrast to a passive immunity which is secured by the administration of antitoxin. The protection afforded by a vaccine is more lasting than that secured from an antitoxin.

PREPARATION.

All vaccines are not prepared alike. Some vaccines are made by suspending dead bacteria in normal salt solution; others are made by lowering the virulence of the infectious agent either by passage through laboratory animals, by means of heat or chemicals or by all three, and still others by a solution of the toxic products of bacteria, which has been partially neutralized. Typhoid vaccine is the most commonly used vaccine, which is composed of a suspension of dead bacteria. Anti-rabic virus illustrates a vaccine which has been attenuated for use for preventive inoculations, by passage through animals. Typhoid, typhoid-paratyphoid, smallpox and rabies vaccines are good illustrations of the prophylactic vaccine.

Those vaccines which are used for the prevention of disease are known as prophylactic vaccines and others used in the treatment of disease are known as therapeutic vaccines. So far the prophylactic vaccines have been the most successful. The therapeutic vaccines have been called autogenous or stock vaccines according to whether they are made of bacteria isolated from the patient, who is to

receive the treatment, or from a type organism or organisms kept in a collection of bacteria secured from various sources.

SERUM.

The blood of animals is composed of the formed elements, red blood cells, white blood cells, etc., and the fluid portion, also called serum. From a medical standpoint serum and antitoxin has been used synonymously. This no doubt results from the method of preparing the antitoxins.

An antitoxin may be defined as any substance which has the power to neutralize or destroy the toxic action of a poison. A serum, blood serum, which has in it an antitoxin, is, of course, an antitoxic serum. Bacterial antitoxins are specific. That is to say an antitoxin which will destroy the poison produced by diphtheria bacilli as it grows will not destroy the toxic effects of poison produced by other bacillus.

METHOD OF PREPARATION.

There is an antitoxin for several of the bacterial diseases, namely, diphtheria, tetanus, meningitis. Antitoxin is a substance produced in the body of animals as a response to a bacterial infection, or a condition which similates a bacterial infection, and is found to be in the blood stream, and is carried in the fluid, serum, portion of the blood. Diphtheria antitoxin is a good type and illustrates well the antitoxins.

To prepare diphtheria antitoxin horses proven to be healthy are injected with small doses of the toxin, which is formed by diphtheria bacilli grown in the laboratory in special medium. When thus injected the diphtheria toxin stimulates the horses' body cells to produce a substance, which will destroy the toxic effect of the diphtheria toxin. The cells always produce more than just enough to neutralize the toxin. The injections are kept up and the horses are bled at intervals to determine the antitoxic strength of the blood. When there is enough antitoxin in the blood to make it profitable the horses are bled. After the bleeding the formed elements of the blood, red blood cells, etc., are separated from the serum portion. The serum contains the antitoxin, and thus the name, "Diphtheria Serum." After certain refining processes the antitoxin is ready to market.

Some of the antitoxins are specific for the cure of disease, diphtheria antitoxin, and others are most reliable as a prevention, tetanus antitoxin.

The protection afforded by an injection of antitoxic serum is of shorter duration than that afforded by a vaccine. The resistance produced is passive, that is to say, that there is no cellular response on the part of the person who is injected. There is no condition produced which similates a diseased condition. This passive resistance lasts after a dose of diphtheria antitoxin for about three to six weeks. The active resistance after the typhoid vaccine lasts about eighteen to thirty-six months.

Antitoxins are given under the skin, into the muscles, into the veins, and intraspinal. These injections are free from harmful results.

The vaccines and serums which have been proven conclusively to be of value in the treatment or prevention of diseases are placed within easy reach of every physician. The commercial firms dealing in drugs and the manufacture of biological products make them in large quantities. Until recent years the distribution of these curative and preventive substances was confined solely to private interests. The prices were high, and for that reason in many instances they were not used. Today the State Laboratory of Hygiene is making and distributing free of charge to all physicians in the state antityphoid and the combined typhoid-paratyphoid vaccines. In the last five years we have given out 28,811 doses of antityphoid vaccine. Last year we gave out 5,783 doses of antityphoid, and 1,177 doses of typhoid-paratyphoid vaccines.

During the epidemic of influenza it was suggested from several quarters that a vaccine might be of value for the prevention of pneumonia, which so frequently complicates the disease. The State Laboratory of Hygiene has prepared a pneumococcus vaccine for distribution to those who would like to take it. The vaccine for the prevention of pneumonia and influenza is yet in the experimental stage and therefore no definite statement regarding its prophylactic value can be made.

By an arrangement which the State Board of Health has been able to make with E. R. Squibbs and Sons the following antitoxins and vaccines are distributed at a very low cost.

Diphtheria Antitoxin—

1000 unit package	$0.50
5000 unit package	2.00
10000 unit package	4.00

Elixir of Enzymes

is a palatable aid to digestion; an agreeable vehicle for iodids, bromids, salicylates, etc., and supplies the curdling ferment for making junket.

Pituitary Liquid (Armour)

(Liq. Hypophysis)

is physiologically standardized and is entirely free from chemical preservatives. ½cc and 1cc ampoules, 6 in box.

LABORATORY PRODUCTS

Extract of Red Bone Marrow

is a great reconstructive and will be found of value to patients convalescing from Influenza and other troubles.

Armour's Surgical Catgut Ligatures

are the finest thing of the kind on the market; they are strong, smooth and sterile. Plain and 10, 20, 30 and 40 day Chromic, sizes Nos. 000 to 4, inclusive. At present, 60 inch lengths only

ARMOUR AND COMPANY

CHICAGO

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Take Advantage of Our

OCULIST CO-OPERATIVE POLICY

A Combination of

"SELF-RITE" and "EVER-LOCT" MOUNTINGS

ACCURATE, PROMPT PRESCRIPTION SERVICE

And a policy of distribution, which has been the means of our rapidly becoming the oculist's favorite prescription house.

Write for particulars

UHLEMANN OPTICAL COMPANY

Mallers Building **5 S. Wabash Ave.** **CHICAGO**

Tetanus Antitoxin—

1500 unit package	$1.67
3000 unit package	2.87
5000 unit package	4.00

Smallpox Vaccine—

Package of 5 Capillary Tubes	$0.40
Package of 10 Capillary Tubes	.80
Package of 5 Glycerinated Points	.40
Package of 10 Glycerinated Points	.80

Meningitis Antitoxin—

Two 15 c. c. syringes	$6.00

These antitoxins can be purchased from at least one druggist in every County in the State for the prices quoted. The State Board of Health prices on 1,000 and 5,000 unit packages of diphtheria antitoxin are 50c and $2.00 respectively. Other prices on the same antitoxin are $2.00 for 1,000 units and $7.50 for 5,000 units. These later prices on antitoxins, particularly if large quantities have to be used, are prohibitive to the poor. The use of antitoxin early in the course of the disease and in large quantities, 10,000 to 15,000 units of diphtheria antitoxin the first inoculation and a repetition of this amount every twelve to twenty-four hours unless the patient shows signs of improvement, gives the most successful results. No case of diphtheria need die. The antitoxin given early and in effective dosage produces a cure.

The value of vaccines as curative agents is doubtful but for prevention there are some which have undoubted value. Some of the prophylactic vaccines are: typhoid, paratyphoid, smallpox, antirabic.

The serums may also be divided into curative and preventive. Some are most effective for prevention, antitetanic serum, while those which are curative, diphtheria, may also be used for prevention.

Since the war began it has been impossible to get salvarsan and neo-salvarsan. These two drugs do not, of course, come under the head of either serums or vaccines. However, since frequent requests for information concerning the substitution for salvarsan and neo-salvarsan are received, it may be well to say just a word about them. Several laboratories in this country began making these substitutes as soon as there was a scarcity of the original drug. Just recently in the United States certain laboratories have been licensed to manufacture compounds known as arsphenamine (Salvarsan) and neo-arsphenamin (Neo-salvarsan). These laboratories are the Dermatological Research Laboratory, 1818 Lombard Street, Philadelphia, Pa.; Takamine Laboratory, 120 Broadway, N. Y.; Farbeurke Hoechst Co., 122 Hudson St., New York City; and Diarsenol Co., 475 Ellicott Square, Buffalo, N. Y.

There is manifest among laymen a good deal of fear concerning the administration of serums and vaccines. Some of this comes from the fact that in past years very serious accidents have happened because of bacterial contamination. The occurrence of such a thing is now doubly guarded against. The manufacturer tests these products for sterility both on artificial culture media and animals, and in addition the government tests them before they can be sold. Serums or vaccines showing contamination can not be sold. Government control has been a very efficient additional safeguard against the sale of bad biological products.

HOW CANADA TREATS HER WOUNDED SOLDIERS.

When the Military Hospitals of Canada found their facilities for caring for returned wounded soldiers insufficient, they called upon the civilian hospitals for aid. Among those which responded with alacrity was the Vancouver General Hospital, whose first allotment was three hundred returned sick and wounded soldiers. Fearing that the accommodations at Vancouver General were inadequate to meet the rapidly increasing demands, the men and women of Vancouver entered upon an enthusiastic and carefully planned compaign to raise money to construct a military annex which is described in *The Modern Hospital* for October. The building and equipment were a gift from the citizens of that city to Vancouver and the province, and have been in use now for about two years.

The arrangements of the Vancouver General Hospital and the Military Annex are somewhat unusual. Vancouver General supplies the complete service, except the medical officers and military officials needed for clerical work, discipline, etc. The hospital is, therefore, practically civil in administration though the medical resident officer is military and deals directly with the general superintendent in matters arising out of civil detail. The arrangement has proved both practical and harmonious and would seem to be admirably adapted to reconstruction requirements.

BOOK REVIEWS

SURGICAL CLINICS OF CHICAGO, August, 1918, Vol. 2, No. 4. W. B. Saunders Co., Philadelphia.

The Surgical Clinics of Chicago continues to maintain its high standard and covers the usual very large field of surgery, from "Tumors of the Pituitary Gland—Technic of Operative Approach," by MacArthur, to "Surgical Treatment of Needles in the Hand," by McWhorter.

Bevan in discussing skin grafting, mentions a point that should be impressed upon the mind of every surgeon; that grafts taken from other individuals seldom live. "I think it would be a fair statement to make that not more than 10 per cent of the grafts taken from other individuals will heal in and remain permanently. To make the matter still stronger, I should say that there is ten times the probability of the grafts taken from the same individual living after their transplantation than grafts taken from other individuals. I do not believe that this very important fact is recognized by the profession. Every few months one picks up a paper describing a case of skin grafting in which the relatives of the patient, or the friends, or fellow employees of the patient very generously and heroically contributed a certain amount of their own skin to cover the extensive area which had been destroyed by burn or injury. I must personally confess that for a number of years I was under the impression that grafts taken from other individuals were quite as apt to live as those taken from the patient himself. In grafts from mother and father and sisters and brothers, we have, at the end of a week been greatly gratified to see how well the grafts were taking, and then found to our dismay, at the end of twelve or fourteen days that the grafts had melted down and that we had accomplished little or nothing. I would like, therefore, particularly to emphasize the importance of removing the grafts from the individual himself."

McWhorter interestingly discusses the "Surgical Treatment of Needles in the Hand." The removal of broken needles from tissues is one of the most difficult of surgical proceedures, due, first, to the inability to palpate them; second, to the danger to adjacent tissues of searching for them with a cutting instrument, and third, to the inability to see them until they have been dissected out. The fluoroscope is of great assistance in such cases and is a great improvement over the time-consuming, extensive and too often fruitless dissection." "A review of 72 cases from Bellevue Hospital discloses the fact that in 53 per cent of the cases the needle could not be located at the first operation. Of the 53 per cent, 13 per cent were reoperated, 24 per cent of the needles being removed at the second operation; 10 per cent were operated upon twice without success: 5 per cent of the needles were discovered at the third trial; and one patient was operated upon five times before the needle was found." McWhorter highly recommends the fluoroscope as an aid in these cases.

The important subject of Pyelonephritis is very admirably discussed by Culver. In discussing the routes of renal infection he concludes that all three theories, Lymphatic extension, blood stream, lumen of ureter, must be given consideration. That this condition is frequently overlooked is shown by the analysis of 90 patients with proved pyelonephritis entered Cook County Hospital in 1917—in which the admitting diagnosis was as follows:

Cystitis	12	Sciatica	3
Pyelitis	10	Cholecystitis	3
Renal Calculus	8	Hysteria	2
Pneumonia	8	Hematuria	2
Salpingitis	7	Uterine Fibroids	2
Typhoid Fever	6	Acute Bronchitis	2
Appendicitis	6	Influenza	2
Nephritis	4	Papilloma of Bladder	1
Abdominal Tumor	4	Malaria	1
Pleurisy	3	Meningitis	1
Renal Tuberculosis	3		

While these diagnoses represent conclusions rapidly made, they serve to emphasize in a very striking manner the condition which renal infections may simulate and from which they must be distinguished. As previously mentioned and noted in the above table, acute abdominal conditions are closely simulated. This fact has been made emphatic by the occasional laparotomy performed, finding the abdominal organs normal. Some innocent structure is usually removed during the operation on the operator's guess that it may be the seat of the disease. After the operative recovery, however, the symptoms continue as before.

In speaking of treatment proper, attention is called to the correct method of administering Hexamithylenamin.

Treatment of the Tumors of the Bladder, and of that most difficult condition, Urethral Carnucle by Fulguration, is illustrated by Kretschmer.

The volume closes with a splendid clinic on Fractures by Hessert.

Among the many important points one may repeat the following extracts:

In case of musculospiral paralysis he says, "You must make the earliest possible diagnosis of the condition as to its being primary or secondary, and you do that by examining in a routine manner for paralysis of the nerve at the time you first see the fracture. Primary paralysis demands immediate operation.

"With reference to operating on Colles' fracture where the cosmetic result is not as good as it might be, I should say, 'Don't do it.'—

"Don't put anything *inside* the medullary cavity of bone except it is an *autogenous* bone-graft or bone-inlay."—

"We have survived the furore which came with the Lane plate, and have learned by experience to demand that certain indications be fulfilled before advising operation. The *first* indication is that every other possible method of reduction has been tried and has failed to secure satisfactory reduction. A little displacement is of no moment when, in our experience, function will be restored."—

"Question: Hoy do you splint a Colles' fracture?"

"Dr. Hessert: The main thing is *reduction.* After you have reduced a Colles' fracture, some go so far as not to put on any splint at all. I would not do that. If the fracture is properly reduced I, personally, would treat it with anteroposterior wooden splints, running the posterior splint from the head of the radius to the metacarpal phalangeal junction and the anterior one sufficiently short, giving the patient free motion of the thumb and fingers."—

The important thing about so-called "fractures of the patella" is the lateral laceration of the capsule, and in an operation for the fracture of the patella the important thing is to repair this lateral laceration, much more so than to repair the patella itself."—

"You want two views of every fracture, unless it is a fracture of the hip or a fracture of the skull. But in a fracture of one of the extremeties don't base an opinion on one view only, you must have two views."—

"Fractures in the X-ray picture always look worse than they are in reality. The X-ray picture is only a shadow, and I have cut down on fractures and found they were not as badly displaced as I thought they were from the looks of the picture."

The number as a whole is well worth study by all who do general surgical operations. F. G. C.

ABSTRACTS OF WAR SURGERY. 430 pages. C. V. Mosby Co., 1918. Price $4.00.

This little volume, prepared by the Division of Surgery, Surgeon General's Office, is an abstract of the war literature of general surgery that has been published since the declaration of war in 1914.

Quoting from the preface, "The preparation of these abstracts, in common with all other early war activities, was an emergency measure. Much of the excellent surgical work which had developed as the result of French, English, and Italian effort, had to be appropriated by our medical personnel at a time least favorable for quiet mental effort." To meet the needs of the situation the Division of General Surgery of the Surgeon General's Office prepared, collected, and arranged abstracts of important general surgical papers bearing on war surgery, and after having same mimeographed, distributed one hundred of them to the various surgical instructors in the army surgical schools and to the surgical chiefs of the war hospitals. The present volume is a response to the demand for a wider distribution of these abstracts, collected and printed in book form.

Under general topics, the organization of medical forces in the field is detailed; the importance of the X-ray in war surgery as an adjunct to the operating team is emphasized; the choice of an anesthetic has resolved itself into the general use of warm ether vapor instead of chloroform, which was used extensively in the early part of the war; the later developments in the treatment of infected wounds is considered in detail and the various antiseptics which have been employed are discussed.

The discussion of abdominal wounds is interesting, inasmuch as this question has arisen in connection with every war. It is pointed out that cases operated upon early do better than those not operated upon. If, however, conditions are such that early operation is impossible, it is better not to operate at all, as the mortality following the late operations was so marked as to be very discouraging. Inquiry into the causes of death after abdominal wounds established the following facts: first, that injuries were as a rule of such a nature, that recovery must be a very rare event; second, that hemorrhage was a chief cause of early death; third, that bullets produced very extensive injuries.

The treatment of joint injuries has shown that intra-articular drainage is a disastrous procedure. The best results have been obtained by freeopening of the joint, excision of devitalized tissue, thorough flushing, and closure, with superficial drainage.

The treatment of head injuries has demonstrated that these cases operated on early and evacuated early do badly. Special hospitals were, therefore, established for the head cases, in which the patients requiring operation could be kept for a longer period of time, until evacuation could be carried out with greater safety. It has, also, been shown that a slow pulse in head injuries is not necessarily a symptom of compression and that paralytic symptoms are not due to depression of fragments but to a disturbance or commotion of brain matter, not remediable by operation. A slow pulse is welcomed as a sign that recovery *may* follow, not that an operation is urgently needed. It has, also, been shown that the depression of fragments is not the usual cause of symptoms and their immediate removal is, therefore, not necessary.

In the treatment of fractures the tendency has been to abandon splints and rely upon extension and fixation of fragments. The Thomas splint is in general use in the English army for the treatment of fractures of the lower extremities. The treatment of infected fractures is carried out in two stages: (a) the cleansing of the wound and (b) the setting or reduction of the fracture and its maintenance in apposition. The first stage of the treatment is of most importance, as on its attainment depends largely the success of the second stage.

The larger part of the volume is devoted to abstracts of articles on different phases of war surgery, which have appeared in the medical journals, and classified under: Wound Infection and Treatment, Tetanus, Gas Gangrene, The Abdomen, Joints, Cardio-vascular Surgery, Nerve Injuries, etc.

The little volume being an authoritative and well prepared digest of the important articles dealing with war surgery, published during the last four years, will serve a very useful purpose in making available to the surgeons in civil practice, in a concise, accurate, and readily available form, the lessons learned at the front. The book is, also, supplied with a topic index, which adds to its usefulness. J. F. S.

How much of your income do you fritter away and how much do you invest in W. S. S.? Remember that many of the men at the front give their lives.

MILITARY HYGIENE AND SANITATION. By Frank R. Keefer, M. D., Colonel, Medical Corps, United States Army. formerly Professor of Military Hygiene, United States Military Academy, West Point. Second Edition, Reset. 12mo of 340 pages, illustrated. W. B. Saunders Company, Philadelphia and London. 1918. Cloth, $1.75 net.

The world war has developed a wide sphere of usefulness for this text book on Military Hygiene, originally prepared for the instruction of cadets at West Point. The first edition was issued in 1914, just preceding the great war. Modern warfare necessitated re-writing parts of the first edition and the author acknowledges indebtedness to General Goodwin and Colonel Lelan of the Royal Army Corps for practical suggestions regarding disposal of waste and the hygiene of trench life. The chapter on Physical training was written by Colonel Koehler, director of physical training at West Point. A glossary of technical terms which has been appended will prove most useful for officers who have not received a medical training. Suggestions covered in this work include the care of troops, recruits and recruiting, personal hygiene, physical training, preventable diseases, clothing, equipment, foods and their preparation, water supply, the disposal of waste, sanitation, venereal diseases and alcohol. The book is well illustrated and should be in the hands of all officers charged with the welfare of our troops.

A MANUAL OF OTOLOGY. Seventh edition, revised and enlarged. By Gorham Bacon, A. B., M. D., F. A. C. S., and Truman Laurence Saunders, A. B., M. D., of New York. 583 pages with 204 illustrations and two plates. Lea & Febiger. 1918. Cloth, $3.00.

The demand for a seventh edition of this standard manual on Otology proves its popularity and its need as a text for students and a compact book of reference for the busy practitioner. A thorough revision of the work has been made and some forty pages of new matter with illustrations added. The text dealing with suppurative inflammation of the labyrinth has been given special attention and brought up to date, including a careful consideration of the symptoms and diagnostic tests of labyrinthine involvement. Another chapter is devoted to the ear tests required by the Government for candidates in the aviation service. The work admirably covers the whole subject from anatomy to treatment. It is well illustrated, most readable and will continue to fill its place as a work on this subject almost indispensable to the man who requires something for quick reference.

HYGIENE FOR NURSES. By Nolie Mumey, M. D., Little Rock, Arkansas. Price $1.25.

The author has condensed in 160 pages a vast amount of information on the subject without going into detail and confusing the mind of the student nurse with matter that is not practical in her work. Ten chapters cover the following subjects: Eugenics, Hygiene of pregnancy, Infancy and puberty, Causes and transmission of diseases, Immunity, Food, Water, Air, Ventilation, Heating, and Disinfection. The book is well illustrated and can be recommended as a text book on this subject for the student nurse.

GENITOURINARY DISEASES AND SYPHILIS. By Henry H. Morton, M. D., F. A. C. S., Clinical Professor of Genitourinary Diseases in the Long Island College Hospital. 4th edition, revised and enlarged. 807 pages with 330 illustrations and 36 full page colored plates. C. V. Mosby Company, St. Louis. 1918. Price $7.00.

During the past fifteen years no branch of medicine has made greater progress than that of Genitourinary surgery. A more definite knowledge of the microorganisms concerned and the pathological changes in the urethral tissues have placed this branch of medicine on a scientific and rational basis. The text book of which this is the fourth edition, has played an important part in bringing this about anu those who have been familiar with Dr. Morton's work will be pleased to learn of a new edition which has been entirely re-written and brought up to date. Such newer subjects as the application of the high frequency current to the treatment of benign tumors of the bladder, the use of radium, in carcinoma of the bladder and prostate, the importance of preliminary treatment before operating in cases of hypertrophied prostate, the diagnostic value of the X-ray, the advances made in the diagnosis and treatment of syphilis, etc., have been given careful and minute attention. This is a most elaborate work covering every branch of genitourinary diseases and syphilis. It is absolutely standard and has won a most enviable standing in the literature published on the subject. It is profusely illustrated and the colored plates are unsurpassed.

DISEASES OF INFANCY AND CHILDHOOD, Koplik, 4th edition. Lea & Febiger. 1918. Price $6.00.

In reviewing the fourth edition, one finds the same clear style of expression as in former editions by the same author. The subject matter is well arranged and clearly indexed so that the student or practitioner can easily find the topic desired, the plates good and very enlightening. The author writing from a large personal experience naturally appeals to the practitioner looking for information on mooted points.

The reviewer had hoped to find the chapters on Infant Feeding lay less stress on high percentage of fat in infant feeding and the advocacy of the more simplified methods of whole milk modification method with the three and four hour intervals of feeding which experience during the past five years has proven to be successful, than appears in this edition. Furthermore, no mention is made of the more recent intravenous method of serum treatment in Spinal Meningitis and the combined intravenous and the intraspinous treatment in poliomyelitis or the method of Goodman in the treatment of chorea. This may not be an oversight on the part of the author but simply the desire of the writer not to confuse the reader with methods of treatment whose efficacy are still on trial.

Taken as a whole the new edition of Koplik is one that every practitioner and student will find of great value in the practice of pediatrics. G. H. F.

VACCINES AND SERA IN MILITARY AND CIVILIAN PRACTICE. By A. Goeffrey Shera (Hon. Capt. R. A. M. C.), with an introductory by Sir Clifford Allbutt, K. C. B., M. D., F. R. S. Oxford War Primers, 226 pages, Oxford University Press. 1918. Price $2.50.

This is the latest of that valuable little series of texts, The Oxford War Primers. It is an effort to bring together the bacteriologist and the medical practitioner. There can be no question that such an end is much to be desired. The rapid advances made in recent years with vaccines and sera fully warrants the publication at this time of a short, concise manual on the subject which will be helpful to the man in general practice. This little manual fills a want of this kind. The work is divided into four sections. The first is devoted to vaccines and covers the present position of specific therapy, the principles of active immunization, the preparation and administration of bacterial vaccines, tuberculines and the various disease groups in which vaccines are used. Section two is devoted to sera and the conditions in which they are used. Section three covers specific therapy in special diseases of women and children. Section four is devoted to auto-serum therapy (including salvarnized serum and normal serum therapy).

PRINCIPLES OF BACTERIOLOGY. By Arthur A. Eisenberg. 198 pages. Illustrated. C. V. Mosby Company. 1918. Price $1.75.

This work was prepared by the author from his lectures to students in the Training School for Nurses at St. Vincent's Charity and St. John's hospitals of Cleveland. It is distinctly a text book for the student nurse and is well adapted for this purpose. One very commendable feature is an introduction to each chapter dealing with individual micro-organisms of a section "mode of infection, disinfection and prophylaxis," giving explicit instructions as regards the patient and those who mingle with him, including the nurse, the room and its contents. A complete questionnaire is provided at the end of the book to facilitate the review of the subject.

ARMY ANTHROPOMETRY AND MEDICAL REJECTION STATISTICS. The Prudential Insurance Company of America, in behalf of the Committee on Anthropology of the National Research Council, has recently published an extended discussion of the scientific and practical aspects of army anthropometry and medical rejection statistics, of special interest and value to those particularly concerned with questions involved in the carrying out of the medical provisions and physical requirements under the selective draft.

The publication includes a review of the recruiting statistics of all the principal foreign countries, and the medical causes of rejection in the different armies, with some brief observations on the corresponding rejection statistics of The Prudential. The investigation brings out the wide variation in the physical proportions of recruits and the urgency of more strictly scientific physical standards. The publication is the result of investigations made in behalf of the Committee on Anthropology of the National Research Council, by Dr. Frederick L. Hoffman, Third Vice President and Statistician of The Prudential. The publication is for gratuitous distribution to those who have a scientific and practical interest in the subject-matter of the discussion.

ROENTGEN DIAGNOSIS OF DISEASES OF THE HEAD. By Dr. Arthur Schuller, Head of the Clinic for Nervous Diseases at the Franz-Joseph Ambulatorium, Vienna. Translated by Fred F. Stocking, M. D., M. R. C. Approved for publication by the Surgeon General, U. S. Army. 305 pages, illustrated. C. V. Mosby Company. 1918. Price $4.00.

While the surgical treatment of head conditions should, no doubt, be limited to the specialist or to men of special surgical ability, diagnostic methods of these conditions should without question be the common property of the general practitioner. The medical profession will therefore welcome a work which is intended to make easier the diagnosis of diseases of the head, a subject of which the average practitioner frankly admits he has little knowledge. However, almost every physician has access to a well equipped X-ray laboratory where he can take or send cases for examination and this procedure cannot be too strongly encouraged. The last few years have seen such an increase in the problems associated with intracranial lesions that with laboratory facilities available, a book of this character becomes a practical and profitable investment for any general practitioner. This work is well illustrated with ninety-seven halftones and drawings. An introduction covers the history of roentgenology of the skull, clinical methods of examination and the technique of rentogen pictures of the skull. The first chapter is devoted to the study of the size, shape and thickness of the normal skull, the diseases of the skull and anomalies in the size, shape and structure. The deformities of the skull and injuries of the skull are covered in Chapter two. Chapter three is devoted to the rentogen diagnosis of the intracranial diseases.

MEDICAL CLINICS OF NORTH AMERICA. Volume II, Number 1. (The New York Number, July, 1918). Octavo of 311 pages, 57 illustrations. Published Bi-Monthly. W. B. Saunders Company, Philadelphia and London. 1918. Price per year: Paper, $10.00; Cloth, $14.00.

This issue of the Medical Clinics of North America keeps to the standard established in the first volume. Of especial interest is a contribution by Dr. W. H. Park on Practical Immunization against Diphtheria, a clinic by Dr. Walter L. Niles on Sub-acute Non-tubercular Pulmonary Infection, a contribution by Dr. Oscar M. Schlass, Acetone Body, Acidosis in Children and a clinic by Dr. Josephine B. Neal on Epidemic Meningitis.

The Wisconsin Medical Journal

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TRANSACTIONS
OF THE
SEVENTY-SECOND ANNUAL MEETING
OF THE
STATE MEDICAL SOCIETY OF WISCONSIN
AT MILWAUKEE, OCT. 1, 2, 3, AND 4, 1918

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1918

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Members of the Council.
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Meeting Oct. 1st, 1918, 8 P. M., in the Gold Room of the Hotel Wisconsin, Milwaukee, Wisconsin.

Meeting called to order by the President, Dr. G. Windesheim, Kenosha.

PRESIDENT: The first number on the program for tonight is registration with the secretary. In place of registration I think if the secretary calls the roll, that will answer the purpose of registration.

SECRETARY ROCK SLEYSTER: I will call the roll of counties, and will ask you to respond and give your name.

Roll call by the secretary.

PRESIDENT: Members of the House of Delegates: I take this opportunity to thank you for the great honor you bestowed upon me last year in electing me president. I did not think at that time that it was advisable to take a man of my age and infirmities for president of the State Medical Society of Wisconsin, at a time when so much demand is made on the medical profession in general. I do not believe that I could have done the work had I not had the confidence and regard of the medical profession over the state, which I have found that I have to a much greater extent than I ever thought could possibly be the case. Whenever I have come in contact with the members of the medical profession in Wisconsin, they seem to have taken a great interest in the Medical Society, and to have worked for the Medical Society, and in that way they have assisted me a great deal in carrying on the work.

I trust that I still have some years spared to me, and that after this year is up I may still be useful to the State Medical Society in some other way than being at the head of it.

The meeting will come to order now. The roll call has been had. The next thing on the program is the report of the Committee on Public Policy and Legislation, Dr. Edward Quick, Chairman.

DR. EDWARD QUICK, Milwaukee: Mr. President and Members of the House of Delegates. Owing to the fact

that there has been no meeting of the Legislature this year, and as that seems to be the principal work of the Committee on Public Policy and Legislation, there is little to report.

From time to time things have come up with respect to the medical profession in the national legislature. We have had something to do with these things.

A bill that was proposed to make osteopaths, christian scientists and other isms eligible to commissions in the Army was opposed by the Committee on Public Policy and Legislation, but not very vigorously, owing to the fact that we received information that there was no chance of the bill being passed, as it was under perfect control by other interests.

That is all that the Committee on Public Policy and Legislation has to report.

PRESIDENT: You have heard the report, Gentlemen, of the chairman of the Committee on Public Policy and Legislation. What is your pleasure?

DR. H. REINEKING, Milwaukee: I move that the report be received and placed on file.

Motion seconded.

Motion put and carried.

PRESIDENT: The next business is the report of the Publication Committee. That report is printed in the hand book. Has the chairman of that committee, or any member of the committee, anything to add to that report?

SECRETARY: The chairman of the committee is not present, but will probably be in a little later.

PRESIDENT: Shall we postpone that report until he comes?

SECRETARY: Yes. That would apply also to the report of the Committee on Medical Defense.

PRESIDENT: We will postpone hearing from the Committee on Publication and the Committee on Medical Defense until later.

The next thing on the program is the election of a committee of 12 on nominations, one member from each district.

SECRETARY: You will remember, Gentlemen, that this is the committee which nominates the officers for the coming year. In past years we have usually had to call the counties in each district, so that some one would place in nomination some man from that district.

DR. H. REINEKING, Milwaukee: Mr. Secretary, can you appoint any member of the Society, or must it be members of the House of Delegates?

SECRETARY: Yes, this House of Delegates. That includes of course, the councilors, who are ex-officio members of the House of Delegates.

The following names were placed in nomination:

1st district: Dr. G. E. Peterson, Waukesha.
2nd district: Dr. J. S. Keech, Kenosha.
3rd district: Dr. J. F. Pember, Janesville.
4th district: Dr. Wilson Cunningham, Platteville.
5th district: Dr. J. A. Junk, Sheboygan.
6th district: Dr. F. M. McGauley, Fond du Lac.
7th district: Dr. G. J. Egan, La Crosse.
8th district: Dr. W. J. Ragan, Shawano.
9th district: Dr. Joseph Smith, Wausau.
10th district: Dr. W. H. Parke, Glenwood.
11th district: Dr. J. M. Dodd, Ashland.
12th district: The names of Dr. Franz Pfister, Milwaukee, and Dr. Herman Reineking, Milwaukee, were placed in nomination, and the House of Delegates proceeded to vote by ballot, with the result that Dr. Herman Reineking was nominated from the 12th district.

The foregoing nominees were on motion duly seconded and carried, elected as members of the Nominating Committee.

PRESIDENT: I should advise that the members of the Nominating Committee meet tonight and make arrangements as to what time they can have a further meeting. They are supposed to bring in their report the first thing on the morning of the second day of the session, which will be Thursday morning. The first business before the House of Delegates on Thursday morning will be the report of the Nominating Committee.

Dr. Patek is now here and we will listen to the report of the Committee on Publication, of which Dr. Patek is chairman.

DR. A. J. PATEK, Milwaukee: The report has been printed in the pamphlet and distributed, and I have nothing to add to it. Dr. McMahon is not here. I thought that he might have something to say with reference to the report. In case it has not already been noted, I desire to call attention to the fact that Major Sleyster is the editor of the Journal, and that he has improved upon the Journal in many ways. I want to congratulate the Society upon our having secured his services.

REPORT OF PUBLICATION COMMITTEE.

Sept. 1, 1918.

To the Members of the House of Delegates, State Medical Society of Wisconsin.

GENTLEMEN:—

The most pertinent circumstance worth recording is that the exigencies of war, with its consequent loss of man power, have given the Publication Committee a very acute realization of dangers that threatened the Journal but which fortunately have been successfully met. Dr. Louis M. Warfield, who had so ably conducted the Journal in the past three years, has relinquished his various professional engagements and accepted army service. During the early months of his absence, thought to be but temporary, your secretary, Dr. Sleyster, was prevailed upon to undertake the editorship. When it became known, however that Dr. Warfield would not return to duty, the selection of Dr. Sleyster as editor was made

permanent. We consider ourselves peculiarly fortunate in this choice, and the character of the issues published under the new management is of a quality in keeping with that which our knowledge of, and confidence in, Dr. Sleyster, gave us every reason to anticipate. To Dr. Warfield go our best wishes in his new field; and for Dr. Sleyster we ask the assistance of the members of the Society in his efforts to keep our publication in the forefront among State Medical Journals.

We record our profound sorrow at the death of one of our former editors, Dr. A. W. Myers. His conduct of the Journal was of the highest order, his devotion marked by the deepest sincerity, his results thoroughly appreciated.

The financial statement, prepared by Dr. McMahon, the managing editor, and appended hereto, shows an increased cost of the Journal as compared with last year's figures. This increase is largely accounted for in the comparative statement of costs, also attached. We congratulate Dr. McMahon for an exhibit which, considering the difficulties with which he was confronted, are to be regarded as very gratifying.

Respectfully submitted,

ARTHUR J. PATEK,

Chairman of Publication Committee.

Milwaukee, Wis., August 14, 1918.

Arthur J. Patek, M. D., Chairman,
508 Goldsmith Bldg.,
Milwaukee, Wis.

My Dear Doctor Patek:

Enclosed you will please find report showing the circulation, earnings, expenses and disbursements of The Wisconsin Medical Journal during the period from August 1, 1917, to August 1, 1918. In order to make the report more readily comparable to the preceding annual report, your attention is respectfully directed to the following data:

Total earnings from Aug. 1, 1916, to Aug. 1, 1917	$3,664.47
Total earnings from Aug. 1, 1917, to Aug. 1, 1918	3,676.07
Total collections from Aug. 1, 1916, to Aug. 1, 1917	4,350.88
Total collections from Aug. 1, 1917, to Aug. 1, 1918	5,090.02
Total expenses from Aug. 1, 1916, to Aug. 1, 1917	5,058.91
Total expenses from Aug. 1, 1917, to Aug. 1, 1918	5,222.33
Total uncollectible accounts charged off in the report covering the period from Aug. 1, 1916, to Aug. 1, 1917	none
Total uncollectible accounts charged off in the report covering the period from Aug. 1, 1917, to Aug. 1, 1918	375.74

This $375.74 represents the only uncollectible accounts charged off since Jan. 1, 1914, at which time $254.24 were charged off. The $254.24 charged off Jan. 1, 1914, and the $375.74 charge off during the last year represents the total accounts charged off as uncollectible since the Journal was taken over by The State Medical Society.

Total circulation to members of The State Medical Society from Aug. 1, 1916, to Aug. 1, 1917	22,044
Total circulation to members of The State Medical Society from Aug. 1, 1917, to Aug. 1, 1918	22,220
Cost of each copy forwarded to members of The State Medical Society from Aug. 1, 1916, to Aug. 1, 1917	6-7/10c
Cost of each copy forwarded to members of The State Medical Society from Aug. 1, 1917, to Aug. 1, 1918	9½c

From the above comparison it is seen:

That the earnings during the period from Aug. 1, 1917, to Aug. 1, 1918, exceeded those of the preceding year by $11.60;

That the total actual expenses during the period from Aug. 1, 1917, to Aug. 1, 1918, exceeded those of the preceding year by $163.42, $85.00 of which was a charge-off for an eight year old typewriter which was no longer repairable;

That $375.74 were charged off as total uncollectible accounts from Jan. 1, 1914, to date; and

That the $85.00 charged off for the typewriter and the $375.74 charged off as uncollectible accounts for the four year and seven months period explains practically all of the advance in cost per copy from 6-7/10c to 9½c.

The principal difficulty which the Managing Editor has experienced during the last year is the forwarding of copies so that they shall reach the members in military service. In view of the number of copies forwarded which did not reach the members, in view of the requests for a second copy and in view of the fact that the gross cost per copy is 12c, a policy of withholding copies for those in service who do not keep the Managing Editor apprised of their current address has been adopted and becomes effective September 1st.

Respectfully submitted,

J. P. MCMAHON,

Managing Editor.

THE WISCONSIN MEDICAL JOURNAL.

PUBLISHING COST STATEMENT.

August 1, 1917, to August 1, 1918.

Income from publishing—		
Advertising, gross charges	$3,639.47	
Less Discounts	216.25	
Net income from advertising	$3,423.22	
Subscription	36.60	
Co-operative Medical Advertising Bureau surplus	29.90	
Total income from operation		$3,489.72 $3,489.72

Publishing expenses—

Printing	$2,549.04		
Salaries	1,350.00		
Commissions for securing advertising contracts	805.89		
Postage	298.05		
Cuts, drawings, etc	13.85		
Office supplies and expenses	46.25		
Miscellaneous general expenses and depreciation	159.25		
Total publishing expenses		$5,222.33	
Bad debt loss—uncollectible accounts		375.74	$5,598.07
Net cost of publishing the Journal			$2,108.35

To members of The State Medical Society:

This deficit of $2,108.35 represents the cost to The State Medical Society of circulating 22,220 copies of the Journal, or about 9½c a copy.

THE WISCONSIN MEDICAL JOURNAL.

FINANCIAL STATEMENT.

August 1, 1917, to August 1, 1918.

Cash balance August 1, 1917		$ 83.25	
Receipts—			
State Medical Society	$1,515.50		
Advertising	3,490.50		
Subscription	33.80		
Co-operative Medical Advertising Bureau surplus	29.90		
Halftones, zinc etchings and sale of old typewriter	20.32	5,090.02	
			$5,173.27
Disbursements—			
Equipment	$ 75.00		
Printing	2,919.06		
Salaries	1,410.00		
Commissions	286.63		
Postage	296.00		
Office supplies and expenses	46.25		
Miscellaneous general expenses	68.25		
Halftones, zinc etchings and State Medical Society collection inserts	34.67		$5,135.86
Balance on hand August 1, 1918			$ 37.41

Assets.

Office equipment	$ 175.13	
Cash in bank	37.41	
Accounts Receivable	1,986.26	
Merchandise	42.12	$2,240.90

Liabilities.

Accounts payable	$1,007.64	
Credit balance on advertising accounts	207.50	$1,215.14
Assets exceed liabilities		$1,025.78

PRESIDENT: Gentlemen, you have heard the report of the Committee on Publication. Is it accepted as printed in the hand book?

DR. L. F. JERMAIN, Milwaukee: I move that the report be accepted.

Motion seconded.

Motion put and carried.

PRESIDENT: We will now listen to the report of the Committee on Medical Defense.

DR. A. J. PATEK, Milwaukee: It has been rather difficult for me to get into wireless communication with Dr. Seaman, who is now at the front, and in consequence I took it upon myself to furnish the Society with a report. This report is also published in the preliminary booklet, and I would call attention not so much to the remarks as to the classified report of the character of cases, and the results of the action in these cases that the Society has thus far defended. I think it shows an enviably good record. It would be folly to take up your time now in discussing any of these paragraphs. Any of you who are interested in individual cases may get further information by communicating with me. I have gotten up a file that I keep for this purpose in which the cases are numbered and tabulated for easy reference.

REPORT OF COMMITTEE ON MEDICAL DEFENSE.

To the Members of the House of Delegates, State Medical Society of Wisconsin.

GENTLEMEN:—

In presenting a report of the Committee on Medical Defense, I believe that no better demonstration of the character of the work done can be made than by amplifying the previous tabulated annual records, thus bringing them up to the present date.

There are here presented a total of 107 cases that have been submitted to us since 1908. Various motives have actuated those bringing suit; in quite a number of instances an attempt to force payment for services rendered gave rise to counterclaims; some suits were entered in good faith; many were based on misunder-

standing of the actual facts by the attorneys; some were engineered by conscienceless attorneys; and there were a number that gave us much perplexity and should preferably have been settled out of court. Under the ruling of the House of Delegates, however, all these were properly entitled to our assistance, and this was accorded them in the greatest possible measure. The result is shown in the subjoined records. Action on two (2) suits will be postponed until after the war because the defendants have accepted army service. Other similar instances may also be held in abeyance.

I wish to call your attention to the first tabulation which notes the number of new cases annually reported. You will see that during 1917 only 7 were added, and in 1918, 10, three of which are but threats upon which it is expected no action will be taken. I can offer no reason for this reduced number in the past two years, and hardly dare hope that it is more than a fortunate accident. But it is gratifying information, nevertheless, for with the remission of dues of those who are serving in the army, the income of the Defense fund will be materially reduced. It has been possible hitherto, to keep just within our money allotment, this despite the low cost of the protection granted. We trust there will never be need of coming before you, with apologies profuse, to humbly ask for an increase in the per capita assessment.

REPORT OF ANNUAL NUMBER OF NEW CASES,

1908-1918.

	New cases	Total
1908-1912		39
1913	9	48
1914	17	65
1915	12	77
1916	13	90
1917	7	97
1918	10	107

CASES CLASSIFIED AS TO CAUSE OF ACTION.

(The bracketed numbers are those of the secretary's files, and are inserted for easy reference. There is some discrepancy in the totals of this tabulation, as compared with the second table below, but this is accounted for by the duplication of some suits, and by the unknown character of some threatened actions.)

Improper and Negligent Medical and Surgical Diagnosis and Treatment		22
Won (18, 32)	2	
Dismissed (10, 31, 39, 71, 75, 48, 82)	7	
Pending (19, 38, 42, 44, 57, 63, 81, 88, 90, 96, 99, 100, 102)	13	
Improper Treatment of Fractures		30
Pending (4, 25, 36, 40, 43, 59, 60, 66, 67, 83, 97, 98)	12	
Dismissed (5, 6, 9, 10, 12, 16, 23, 46, 74, 76)	10	
Withdrawn or not defended (7, 8, 35, 68, 72)	5	
Win (37)	1	
Lost (89, 93)	2	
Improper Treatment; Needless Amputation Charged		8
Pending (44, 63, 64, 77)	4	
Disagreement (69)	1	
Won (27, 45)	2	
Dismissed (90)	1	
Responsibility for Development of Post Operative Hernia		2
Pending (70)	1	
Disagreement (50)	1	
Improper Treatment of Newborn		2
Dismissed (41)	1	
Lost (46)	1	
Improper Diagnosis in Case of Insanity		1
Pending (65)	1	
Improper Treatment of Mastoid Disease		3
Pending (49, 62)	2	
Lost (92)	1	
Improper Treatment of Confinement		4
Dismissed (21)	1	
Disagreement (24)	1	
Won (2)	1	
No Jurisdiction (79)	1	
Responsibility for Death from Anesthetic		4
Won (30, 34)	2	
Dismissed (56)	1	
Pending (84)	1	
Leaving Foreign Body in Wound after Operation		3
Won (20)	1	
Pending (60)	1	
Dismissed (22)	1	
X-Ray Burn		4
Pending (28)	1	
Dismissed (29)	1	
Threatened (33, 91)	2	
Miscellaneous (1, 3, 13, 26, 47, 52, 53, 68, 85)		9

CASES CLASSIFIED AS TO RESULT OF ACTION.

Total number of cases considered since 1908	107
Cases tried before jury with verdict for defendant (2, 18, 20, 27, 30, 32, 34, 37, 45, 52, 53, 69, 75, 82)	14
Suits dismissed and non-suited (upon trial)	29
Jury disagreed	3
Further course of these uncertain.	
Cases lost	4
No. 89.	
No. 46. Damages assessed, $300.00.	
Nos. 92, 93. Lost, and appealed to Supreme Court.	
Cases now pending	34
(4, 19, 25, 28, 36, 38, 40, 43, 44, 49, 55, 57, 59, 60, 61, 62, 63, 64, 65, 66, 67, 70, 77, 81, 83, 84, 90, 91, 92, 96, 97, 98, 99, 102.)	
Of these will probably not come to trial	21
Trial due	13
Cases brought to committee's attention but withdrawn and placed in the hands of insurance companies	4

Two cases are stayed by court order until defendants' return from military service.

Cases entered but withdrawn or refused because they did not come under the society's jurisdiction 8
(7, 8, 13, 14, 47, 48, 79, 94.)

Suits threatened but no action begun..... 14
(29, 33, 42, 72, 73, 80, 85, 86, 87, 88, 94, 97, 100, 103.)

ARTHUR J. PATEK,

Secretary Medical Defense.

FINANCIAL STATEMENT.

	Received	Oct. 1, 1915. Expended
1908—June 22	$1,252.00	$ 8.60
		87.50
1909—June 28	1,280.50	128.10
1910—June 21	1,508.50	1,079.66
1911—June 3	1,572.50	2,178.01
1912—June 6	1,596.50	625.64
1913—Sept. 29	1,797.00	3,581.25
1914—Sept. 30	3.222.00	4,000.00
1915—Oct. 1	3.279.00	999.65
1916	3,306.00	Oct. 1916, 2,500.00
1917	3,370.00	Oct. 1917, 2,500.00
To Aug. 1918	2,717.00	Apr. 1918, 1,000.00
		(Settled to Sept. 1918.)

PRESIDENT: If there is no more to add to the report, a motion for its acceptance is in order.

Motion made that the report be accepted and placed on file.

Motion seconded and carried.

PRESIDENT: The motion is carried and the report is accepted. We will now listen to the report of the Committee on Health and Public Instruction.

SECRETARY: They have no report to make. Dr. Evans is in France, and his committee has been inactive this year.

PRESIDENT: The next business on the program is the report of the Committee on Medical Education, Dr. Jermain, Chairman.

DR. L. F. JERMAIN, Milwaukee: There is nothing to add to the report as printed in the hand book.

REPORT OF COMMITTEE ON MEDICAL EDUCATION.

At no time in the history of this country has the need for well trained medical men been so urgent as at present. At no time have the prospects for a successful medical career been so promising. The factors operative in bringing about this state of affairs are: (1) The reduction in the number of medical schools and the consequent reduction in the number of medical students and graduates. In 1904 there were 162 medical schools in the United States with an attendance of 28,142 and 5,747 graduates for the year. In 1918 the number of medical colleges was 96, the number of students 13,630 and the number of graduates 2,670 for the year. (2) The increasing demand upon the medical profession through specialization, public health work, social service, medical education and the industries. (3) The necessity of supplying the splendid and rapidly growing armed forces of the United States with trained medical officers.

It was soon realized that a continuous supply of well trained medical men, both during the war and after the war, especially during the reconstruction period, was an absolute necessity and that this country must not commit the error of its allies and allow medical education to be impaired.

Great as is the need for more medical men there is still greater demand for better medical men, hence many and perplexing are the problems, the solution of which will insure not only quantity but quality. The listing of essential teachers, the formation of the Enlisted Medical Reserve Corps and the Student's Army Training Corps are measures which will exempt medical students and teachers from the draft and will undoubtedly maintain the number of students at the present low figure and guarantee high grade training for them. Young men therefore who by inclination and previous training are fitted for the study of medicine should be encouraged to do so, as in no other manner can they better fulfill their patriotic duty towards their country.

In the modern Class "A" Medical School the intensive and individual laboratory and clinical instruction makes it imperative that classes be limited in size. Only in this manner can high grade training be guaranteed and the greater the endowment of the school the more surely will there be restriction in the number of students admitted. The Class "A" Medical Schools of Minnesota, Michigan, Illinois, Ohio, Pennsylvania and New York can do little more more than supply the needs of their own communities. If Wisconsin wants well trained doctors its citizens must assume the burden and through state aid or endowment make it possible to train them and there can be no excuse for shifting this responsibility to others.

Fully as serious as the scarcity of practitioners is the dirth of internes. Even though the Surgeon General's office wisely insists that young men serve their internships in civilian hospitals prior to their being commissioned in the army it is practically impossble for Wisconsin Hospitals to secure them. Today there is hardly a hospital in this state with a sufficient number of internes to carry on the work properly. A fifth and compulsory hospital year should be immediately added to the medical curriculum and the necessary legislation enacted to make this a requisite for license. Wisconsin may well be proud of the fact that both its medical schools are of high class and that there is none but that healthy and friendly rivalry which is conducive to better work. The medical profession should seek every opportunity of impressing the public with the fact that the

cost of good medical education cannot be borne by the student and that liberal support must be forthcoming for the schools.

The post-graduate courses instituted by the medical school of the State University bid fair to be of inestimable service to the profession of this state and should be encouraged and liberally supported.

Respectfully submitted,

LOUIS F. JERMAIN,
CHARLES R. BARDEEN,
J. VAN DE ERVE.

PRESIDENT: As there is nothing to add to the report as printed in the hand book, a motion to accept the report as printed is in order.

Motion made that the report as printed be accepted and placed on file.

Motion seconded and carried.

PRESIDENT: The next thing on our program is the report of the Committee on Necrology, Dr. Rock Sleyster.

SECRETARY: This report has been published in the hand book, and there is nothing further to add to it.

REPORT OF THE COMMITTEE ON NECROLOGY.

To the House of Delegates:

The following is the report of the Committee on Necrology, including deaths reported to Sept. 1st. Names of members of the Society are printed in italics.

ROCK SLEYSTER, *Editor, Chairman.*

Binnie, John ..... Poynette
Barnes, H. L. ..... Ripon
Carmachan, G. H ..... Bruce
Crawhall, G. H ..... Seattle
Cunliffe, R. A ..... Milwaukee
Christman, E. G ..... Spring Green
Scanlon, C. A ..... Manawa
Cronyn, Wm. J ..... Milwaukee
Cox, A. J ..... Superior
Cain, C. L ..... Elmwood
Clason, Jesse A ..... Fond du Lac
Dalton, Chas. C ..... Wiota
Dudley, E. H ..... Janesville
Edwards, Hugh J ..... Milwaukee
Evans, J. M ..... Evansville
Evans, N. C ..... Mt. Horeb
Fraser, A. C ..... Manitowoc
Frank, L. F ..... Milwaukee
Floyd, R. G ..... Eureka Springs
Falge, Louis ..... Manitowoc
Goebel, Alfred W ..... Milwaukee
Gill, Jos. F ..... Madison
Gough, Chas. R ..... Wausau
Hansen, Arthur ..... Milwaukee
Heidner, G. A ..... West Bend
Hallock, W. E ..... Juneau
Jones, S. P ..... Marinette
Kavanaugh, Kate S ..... Minneapolis
Kemster, Walter ..... Milwaukee
Lambach, Jennie ..... Milwaukee
Levings, A. H ..... Milwaukee
Mills, James ..... Janesville
McQuillen, James ..... Superior
Myers, A. W ..... Milwaukee
Oyen, Martin ..... Ellsworth
Peaslee, J. H ..... Marinette
Provost, Capt. A. J., M. C ..... Oshkosh
Russell, Thomas P ..... Oshkosh
Rodman, A. J ..... Delavan
Slaughter, A. W ..... Green Bay
Streeter, Martin R ..... Oshkosh
Vance, James W ..... Madison
Webster, G. W ..... Janesville
Wells, A. V ..... Fennimore

Motion made that the report as printed be accepted and placed on file.

Motion seconded.

DR. T. J. REDELINGS, Marinette: Before accepting that report I would like to offer this correction: the name of J. H. Peaslee, of Marinette, is listed here as one of the physicians of this state, and as having died. He was not a physician, but was a dentist, and had no medical degree. I do not know how the error occurred, but his name appears in the hand book.

SECRETARY: The report was made out from the death notices published in the Journal, Dr. Redelings.

DR. REDELINGS: I saw the death notice in the Journal. It was an error there. I do not know how it came to be made.

SECRETARY: That name will be taken out of the report.

DR. REDELINGS: I move the acceptance of the report as corrected.

Motion seconded.

Motion put and carried.

PRESIDENT: We come now to the report of the Committee on Social Insurance, Dr. A. W. Gray, Chairman. Dr. Gray being absent in the Service, some of the other members of the committee may have something to say.

DR. C. H. LEMON, Milwaukee: As a member of that committee I will say that during the year there were no meetings held of that committee. Nothing has transpired during the year.

PRESIDENT: I can verify that statement, because I am a member of the committee, and I know that I never had notice of a meeting. So I think the best thing to do is to accept the report as signed by the chairman. All in favor of this action will signify by saying "aye."

Carried unanimously.

REPORT OF THE COMMITTEE ON SOCIAL INSURANCE.

Base Hospital, Camp Grant, Ill.,

To the House of Delegates of the State Medical Society of Wisconsin:

Your Committee on social insurance submits the following report:

1. No meeting of the Committee has been held since its report was submitted at the last annual meeting of the Society. War conditions have interfered with our work. Three (any more?) members of this Committee are in active army service.

2. A hearing by the special investigating Committee, created by the State legislature, with Senator Albers as Chairman, was held in Milwaukee early last spring. Representatives of all interests likely to be affected were invited to appear and to be heard. The Chairman of your Committee offered the co-operation of our Society in furthering the studies being carried on by the Committee of the State legislature. He expressed his individual opinion that the members of the medical profession would not be found wanting in doing their part in this great undertaking for the betterment of social conditions among our citizens, if statutes just to them and their ideals should be passed by the legislature and become laws.

3. A questionnaire was sent to each licensed physician in the State, through the office of the Secretary of our Society, in the hope of bringing forth information that would be of value to this Committee of the legislature in making its report to the next session of the legislature. A copy of the questionnaire is attached to and made a part of this report. Your Committee does not know at this time how generally this questionnaire was answered by the physicians. Both because of this fact, and because of the character of the questionnaire, there may be some doubt in the value of the information obtained. A questionnaire that would bring out the information needed and that would not, at the same time, put an impractical burden on those answering it, seemed to your Committee an almost impossible thing to construct. The questionnaire, as finally sent out, was approved as the best thing advisable, after an impossibly long one had been objected to by your Committee as unworkable. The Chairman of your Committee found Senator Albers to be a very earnest and conscientious worker, and seemingly to have a real appreciation of the importance of our profession in any scheme of health insurance; and an appreciation also of the necessity of shaping any proposed legislation so that no injustice should be done to our profession.

4. Your Committee finds that there is still much misinformation in the minds of medical men in regard to health insurance, and that there is much unjustified feeling against it. Your Committee wishes to warn the members of the Society again that antagonism based on little understanding of the subject will work greatly to the detriment of the profession. It is to be hoped that our attitude will be that of scientific men, properly skeptical, but at the same time open-minded until reasonably complete knowledge can be truthfully claimed.

Respectfully submitted,

(Signed) A. W. Gray, *Chairman.*
Milwaukee, Wis., Aug. 22, 1918.

President: Next in order is the report of the committee to investigate and report on Medical Defense, Dr. Jermain, chairman.

Dr. L. F. Jermain, Milwaukee: There is nothing to add to the report as printed, Mr. President.

President: There is nothing to add to the report by the chairman of the Committee on Medical Defense. Has any one of the members any remarks or any corrections, or anything to add to the report as printed? If not, a motion is in order for its acceptance.

Motion made that the report as printed be accepted.

Motion seconded and carried.

REPORT OF COMMITTEE ON MEDICAL DEFENSE INVESTIGATION.

This report is based upon information obtained from the Secretaries of the various State Medical Societies, from the Secretaries of the County Medical Societies of our own state, and from an analysis of the work of the Defense Commission since the inauguration of the defense feature.

That data from State Societies came in answer to a questionnaire to their secretaries and from the report of Dr. G. G. Cottam of Sioux Falls who made a similar investigation for the South Dakota Medical Association.

The desired answers were received from all states except Florida and Wyoming. These show that 32 state societies with a membership of approximately 67,500 have medical defense and 14 societies with a membership of 8,500 have no defense. 29 societies finance the defense feature out of their regular dues, two have annual assessments and one Washington pays for its defense by voluntary subscription.

The reports indicate that medical defense has in general proved successful and satisfactory and that not in a single state has it been abandoned. Several states have reported favorably on medical defense and will adopt it in the near future. Membership dues have been raised in many state societies in order to take care of the increasing cost. Payment of annual dues for medical defense is optional in West Virginia and compulsory in all other states except Washington which raises its fund by voluntary subscription.

Most societies engage a legal firm with an annual retainer and per diem for actual services in court. Twelve states report increasing cost of medical defense, nine decreasing cost and four stationary. The California State Medical Society is the only one which pays claims and justments and does it out of a fund raised through voluntary subscription by the majority of its members.

During May, 1918, a questionnaire was mailed by your Committee to the secretaries of the various County Societies of this state. Of the 54 questionnaires sent out only eight were answered and returned. From these returns, meager as they were, your Committee concluded that the majority of the members; are: 1. In favor of medical defense. 2. In favor of continuing it in its present scope. 3. In favor of giving the defense committee greater discretionary powers as to what cases should be defended and. 4. In favor of continuing the defense feature even if the dues must be raised. Of the 1974 members of the State Medical Society 1717 paid their defense dues during the year 1917 and only 157 refused to do so. A large majority of these members are doing emergency surgery and obstetrics and rely wholly upon the protection the state society affords them.

A careful analysis of the cases disposed of by your defense committee and council since 1908 forces this committee to the following conclusions: 1. Medical Defense as conducted has been eminently satisfactory and successful. 2. The cost of medical defense has been moderate considering the results accomplished. 3. Cases defended have been fairly evenly distributed among the specialists in surgery in the larger cities and the general practitioner in the rural districts. 4. The only serious objection made to medical defense is that cases were defended in which gross negligence was manifest. 5. The number of cases defended in which gross negligence was shown were an extremely small percentage of the total. 6. A result, which in the opinion of the expert surgeon in a medical center surrounded as he is by most modern apparatus for diagnosis and treatment, is considered a poor one may in the light of the difficulties attendant upon country practice be considered a fairly satisfactory one.

Your committee therefore recommends that medical defense as conducted in the past be continued and that if the society deem it wise to clothe its defense committee with discretionary powers this committee be enlarged so as to include one or more representative of rural general practice.

Respectfully submitted,

Louis F. Jermain,
Herman Gilbert,
F. P. Knauf,
Jos. Smith.

President: The next number on the program is the report of the Committee on Historical Research. That committee has no report to make.

Dr. H. E. Dearholt, Milwaukee: I am sorry not to have had a report in time for printing in the hand book. The committee has had no meeting since it was appointed, although there has been considerable correspondence among the members, and also outside of the committee. Nevertheless, I feel that the committee has not fulfilled its functions well enough to be continued, and I am disposed to move the discharge of the present committee. I was at first inclined to say that inasmuch as there had been a great deal of doubt in the minds of many people, among them the members of the committee itself, as to whether or not the historical research work could be carried on when the interest of the members is so absorbed in war, both in the news of the war and in the duties of the war, that we give up this attempt at this time. I feel, however, that never before has there been so much reason why a good committee should be acting on the medical history of the state as there is at the present time, and it would, therefore, please me very greatly to see this House of Delegates, if possible, appoint or elect a committee which can carry on this work as it should be carried on. I confess the failure of the committee is mainly the failure of the chairman. I thought I had enthusiasm enough, and time enough to do something on this work, but have fallen down on it, which adds one more failure to the list of failures in the attempt to get some work done on the medical history of the State Medical Society of Wisconsin. I should like to see somebody who can do this work, take hold and do it.

President: You have heard the report of the Committee on Historical Research. What is your pleasure?

Dr. S. S. Hall, Ripon: I move that the committee be dismissed, Mr. President.

Dr. T. J. Redelings, Marinette: Motion seconded.

President: It has been moved and seconded that the Committee on Historical Research be dismissed. What are you going to do with the report—I want to know that first.

Dr. Franz Pfister, Milwaukee: I move you that the report be accepted and the committee dismissed.

Motion seconded.

President: It is moved and seconded that the report of the Committee on Historical Research be accepted, and the committee dismissed. Are there any remarks?

Dr. A. J. Patek, Milwaukee: Mr. President, I will confess I did not hear all of Dr. Dearholt's remarks, but it seems to me it would be a pity if an institution such as the one represented by that committee should be entirely lost. It is possible that the committee might hold over for another year or two. History is in the making, and medical history is in the making too, and Wisconsin is as active in the making of that history as any other state in the country. We are proud of what the medical men of Wisconsin are achieving at the present time at the front. Any historical research of matters medical will include the activities of the Wisconsin men who are engaged in the war, and if this committee is entirely dropped, and the name of that committee, even though inactive, does not appear at all on our program, it is very likely that no such committee will again be established at a future time. It would seem to me better to keep the committee on the program, even in its dormant state, so that—some day—when the history of the present war is to be chronicled, that committee can be resurrected. It would be a mistake to put the committee out

of existence; rather let it stay dormant or latent or inactive or lazy, if you please, but that will insure its return to life some day.

PRESIDENT: Are there further remarks? Gentlemen, I have no objection to having the report of that committee accepted, but personally I do object to the second clause of that motion, which says to discharge the committee, or dismiss the committee. That committee was appointed for a certain purpose, and the purpose was a good purpose, and I should like to see the second part of that motion so amended as to give the committee more time to report. However, if we do not hear any amendment to the motion, the motion is before the House.

DR. A. J. PATEK, Milwaukee: Mr. President, I move to amend the motion to read, that the report be accepted and the committee be continued.

Amendment seconded.

PRESIDENT: You have heard the motion and the amendment thereto. All in favor of the amendment will signify it by saying "aye," opposed "no."

Motion carried.

PRESIDENT: The amendment carries the original motion.

We will now listen to the report of the delegates to the annual meeting of the American Medical Association.

SECRETARY: There is nothing to add to the report as published in the hand book, Mr. President.

PRESIDENT: The report of the delegates to the American Medical Association is printed in the hand book, and there is nothing further to add to it. Are there any remarks with reference to this report. If not, a motion for its acceptance is in order.

DR. H. REINEKING, Milwaukee: I move that the report be accepted and placed on file.

Motion seconded.

Motion put and carried.

REPORT OF DELEGATES TO A. M. A.

To the President and Officers of the State Medical Society.

GENTLEMEN:—

Your board of delegates to the meeting of the American Medical Association begs to make the following report:

The entire board of delegates composed of Drs. Rock Sleyster, Chas. Lemon, and Horace M. Brown, were present at the meeting of the American Medical Association at Chicago, and attended all of the deliberations of that body, all delegates being present at every meeting.

The meeting in Chicago on June 10, 1918, was an extremely important and interesting meeting on account of the many questions relating to matters connected with the attitude of the Association toward the authorities engaged in carrying on the war in Europe. The greater part of the time of the meetings having been taken up with such work.

The board of delegates memorialized the President of the United States and Congress, with a view of urging the retention in office of Surgeon General Gorgas, after the date when his position as Surgeon General shall lapse because of his having reached the age of retirement.

The action of the board of delegates in regard to a number of questions relating to the position of women physicians in their war work, was met by the board in a most liberal and far-sighted manner. The reports of the standing committees of the Association were extremely interesting and the report of the treasurer showed the organization to be in a most prosperous condition. A very full report was made in regard to the outcome of various law-suits against the Association and it was shown that all these suits had been decided in favor of the Association but had failed of success because of the illegality of the claims, without having been brought into court.

In view of the fact that every member of the State Medical Society has in his possession the Journal of the American Medical Association, it does not seem fitting or necessary for the Board of Delegates in this report to enter into details in regard to this meeting, and the Board respectfully refers the members of the State Society to the copies of the Journal of the American Medical Association of dates of June 15, and June 22, 1918, for full and complete details. All of which is respectfully submitted.

H. M. BROWN.

PRESIDENT: Next in order is the report of the Delegate to Council on Medical Education, L. M. Warfield.

SECRETARY: I have a letter from Dr. Warfield saying that the report will be forwarded for publication in the minutes of the meeting. He has been unable, owing to his duties in the Army, to write out the report in time for the meeting.

PRESIDENT: I do not see that there is anything to do but wait until the report is sent in and published.

REPORT OF DELEGATE TO COUNCIL ON MEDICAL EDUCATION.

Your delegate attempted to reach Chicago Feb. 4th but was prevented by the inability of the railroads to get trains through. The report therefore is taken from the abstract of proceedings which was published in the Journal American Medical Association of February 16 and 23, 1918, pages 484 and 559.

The Chairman, Dr. H. D. Arnold of Boston, addressed the meeting on "Medical Education, Medical Interns and the War". He spoke of the development of better standards of medical education which the past few years had seen and of the opportunities for graduate work after the war. He stressed the fact that the essential

for the success of any treatment lies in proper training of those who are to administer the treatment. He urged that the Council continue its work for high standards of education.

The report of the Secretary, Dr. N. P. Colwell, was on "Recent Improvements and Further Needs in Medical Education". He spoke of the gradual improvement in preliminary standards and of the higher types of men now graduated from the medical schools. He felt that the problem of the various Cults—most of them offshoots of osteopathy—would be settled eventually by the appreciation of the public of the great gulf which separated the practitioners of the Cults from high-class medical graduates. He spoke of the dearth of medical schools for negroes and hoped that generous donations from the philanthropic people would be forthcoming so that these schools could be increased in efficiency and others founded.

Prof. George G. Chambers spoke on "Problems in the Administration of Entrance Requirements to Medical Schools". A committee appointed by the Council on Medical Education has prepared the following college requirements for the pre-medical work: Chemistry—twelve semester hours; physics—eight semester hours; biology—eight semester hours, and English composition and literature—six semester hours. A reading knowledge of French or German is strongly urged. He was not in favor of the student's entering his first medical year with any condition. There should also be a nation wide agency to determine college standards so that all colleges attempting to give pre-medical courses would be rated and this information should be available to all medical colleges.

In the discussion all who spoke emphasized the prime importance of the student's ability to speak and write correct and forceful English.

The report of the special committee appointed to study the problem of a standard two-year pre-medical course following the required high school course was presented and adopted. The meeting was then adjourned.

Respectfully submitted,

Louis M. Warfield, M. D.

Next in order is the report of the Delegate to the National Legislative Council. The National Legislative Council did not meet this year, on account of some war work which had taken precedence, so there is no report to make.

Next in order is the report of the chairman of the council, Edward Evans.

Secretary: Dr. Evans is at present in France.

President: Dr. Evans, the chairman of the council, is in France, and I do not believe he could address us tonight. His voice would not reach far enough. I will ask the secretary, who knows all about the proceedings of the council, to make a report in place of the chairman of the council.

Secretary: Mr. President and Gentlemen: No special business came before the council during the past year. The regular annual meeting of the council was held in Milwaukee in January, and the report of that meeting was published in the Journal. There is nothing further to report from the council.

President: You have heard the report of the chairman of the council, as represented by the secretary. What is your pleasure?

Motion made that the report be accepted and placed on file.

Motion seconded.

Motion put and carried.

President: We now come to the reports of councilors of the various districts. We will first hear from the 1st district.

The report of the councilor from the 1st district was presented by Dr. T. E. Peterson, Waukesha, as follows:

With reference to the four counties representing this district, Dodge, Jefferson, Washington and Waukesha, I would say that Dodge County has lost some members, Washington County has lost 3, Waukesha County 1. There are some delinquents. Last year there was a total membership of 125, and 121 members this year. Total loss of 4 members, and there are 5 delinquents. There is nothing further to report. There was no meeting held this year in the district, I think, because of the fact that we were all busily occupied with war work and war duties.

President: You have heard the report of the councilor from the 1st District. What is your pleasure?

Motion made that the report be accepted.

Motion seconded and carried.

President: I will ask the secretary to take the chair while the councilor of the 2nd District reports.

The report of the councilor from the 2nd District was presented by Dr. G. Windesheim, Kenosha, as follows:

I have here a letter from the secretary of one of the county societies of the 2nd District, which explains probably better than anything else that I have seen, the present situation and present conditions in the medical societies: It reads:

While Walworth County Society has held only one formal meeting during the past year, the interest in the work of the Society and of medicine in general has not abated. There has been so much other work of vital importance to the profession and to the community in general, that of necessity the work of the Society had to be shelved. The membership of the Society numbers 29, a gain of 2 during the year. Six of our members are actively engaged in the War. Two or 3 more have commissions which they have not yet accepted. There may be others who have it in mind to join the Army, but they are so reticent, probably owing to their uncertainty, that it is hard to make a satisfactory survey of the

county in that respect. The County Society paid the State Society dues of 5 members who were in the Army at the time. We hope to get time for more meetings during the coming year than we had this year.

Now this is practically the condition of affairs in all of the counties that constitute the 2nd District. Some meetings were held, but not as many as used to be held. Everybody has been busy with the examination of soldiers, and other work, that medical society work has practically had to take a back seat. However, in the 2nd District, Kenosha this year has 34 members as compared to 30 last year, which means a gain of 4. Racine has 46 members, as compared with 38 last year, a gain of 8. Walworth has 28 members, according to the latest report from the secretary, as compared to 28 last year, no gain and no loss. They have 2 new members, and 3 have moved out, or 2 moved out, so altogether the 2nd District has a gain of 11 members. They have 5 delinquents, and 13 new members. The delinquents in all probability will come in again like they did last year. By the end of the year they usually fill up the quota.

We will now listen to the report of the councilor from the 3rd District.

The report of the councilor from the 3rd District was presented by Dr. F. T. Nye, Beloit, as follows:

Mr. Chairman and Gentlemen: I have the secretary's report here giving the Dane County Society 110 members last year, and 104 this year, a loss of 6, with 4 delinquents, 5 removals, and one death.

Columbia County had 30 last year, and 30 this year, no loss and no gain. There were 2 deaths, and 2 new members.

Green had 19 last year, and 20 this year, a gain of one new member.

Rock County last year had 59, this year 58, a loss of one, with 3 delinquents, one death, and two new members.

Sauk County last year 17, this year 17, with one delinquent and one new member.

The conditions existing throughout the district are remarkably good considering the number of men that have been called out. Dane County has been very active all through the year.

Rock County held a post-graduate course which proved to be very valuable to the men in a good many ways.

Otherwise conditions are normal.

PRESIDENT: You have heard the report of the councilor of the 3rd District. What is your pleasure?

DR. T. J. REDELINGS, Marinette: Mr. Chairman, I move that the reports of councilors be accepted without vote, unless there is objection.

Motion seconded.

Motion put and carried.

PRESIDENT: Is the councilor from the 4th District ready to report?

SECRETARY: He is not present.

PRESIDENT: The 5th District, Dr. Zierath.

SECRETARY: He is not present.

PRESIDENT: We will listen to the report of the councilor of the 6th District.

The report of the councilor of the 6th District was presented by Dr. H. W. Abraham, Appleton, as follows:

Mr. Chairman and Gentlemen: The war has not changed conditions very much. Door County has a loss of 2 members, one by death, and one who would not join again because we did not prosecute all the criminals there. I can say this for Door County: it is on its feet better than I think it has been for a great many years. It is holding at least one meeting a year and they have practically all of the men interested in the Society now, and keep up the active membership interests.

I do not know very much about Brown County. I did not get a chance to look into it, although I saw the secretary once. I do not know as to their literary work, but they are keeping up the membership well, and keeping the Society before the men.

Outagamie County has been having regular meetings every month, and I think there has never been a time in the history of the Society that it has been doing such good work in a literary way. It has a gain of one member, being the only society in the group that has gained this year.

Fond du Lac County is always well up in the society work. They have a loss of one, due to death.

Winnebago County has been the poorest in the district this year, as far as keeping up the membership is concerned. However, they are doing good work, and the men are interested. But the work of keeping them together, and keeping up their dues has not had as much attention, I think, as it should have had.

In the whole district we have a loss of only 5, which are all accounted for by deaths and removals from the district.

PRESIDENT: The next district is the 7th, Dr. Evans. Dr. Evans is in France. Dr. Sarles has been asked to take up the work for Dr. Evans, but I guess he is not present.

The next district is the 8th District.

The report of the councilor for the 8th District was presented by Dr. T. J. Redelings, Marinette, as follows:

Mr. Chairman and Gentlemen: War conditions, or some other factors, have had some influence on the activity of my home county society. We have maintained our membership of 22 last year, and 22 this year. We have had no meetings since April, and held our last literary meeting in April. That is partly due to the fact that war activities became centered in our city, owing to the examination there of material from a large territory, and partly because your councilor temporarily laid aside his prod.

Oconto County shows a loss of 4 members, and I think had no meetings. Such of the individuals as are interested in medical work have enlisted in our Society.

Shawano County shows a loss of 3 members. I am not in touch with the progress of the Society from a literary or scientific standpoint.

The district shows a loss of 4 members. Presumably when things have returned to the normal, our usual activity will return.

I have no further report to make.

PRESIDENT: We will now hear from the councilor of the 9th District.

The report of the councilor of the 9th District was presented by Dr. Joseph Smith, Wausau, as follows:

Mr. Chairman and Gentlemen: On account of the pressure of other matters it has not been possible for the councilor for this district to personally visit the different counties, and therefore, I am not able to state just what has been the activity as to meetings. I know that some of the counties have been holding meetings more or less regular.

We have a net loss of 10 out of a membership of 172 last year in the district, leaving 162 in the district. One of these was by death, and 2 were removals. There are two counties in the district that show a gain, Lincoln with 2, and Portage with 3, making a gain of 5.

We have in this district a district medical society which meets regularly every 3 months, that is, holds quarterly meetings. These meetings have been kept up throughout the year, and have been very well attended, and have been very successful. The last meeting was held last Friday at Wausau, and the attendance was in the neighborhood of 30. We had a very enthusiastic and successful meeting. It is our custom to hold these quarterly meetings at different cities in the district, and they have been very satisfactory and very successful, and this year has been no exception.

PRESIDENT: The next district is the 10th, Dr. Cairns, councilor. As Dr. Cairns is not present, we will pass that and listen to the report from the 11th District.

The report of the councilor of the 11th District was presented by Dr. J. M. Dodd, Ashland, as follows:

Mr. Chairman and Gentlemen: The condition in our district remains the same numerically as last year. We had a membership of 109 last year, and there are 109 this year. There has been some falling off in some of the counties, and some additions in others, so that the number remains the same.

The literary and educational work has not been active during the past year. The interest of the profession up there seems to be largely absorbed in War activities, examining drafted men for the local boards, medical advisory board work, and enlistments in the Medical Corps. Our district has given its quota of doctors to the medical service of the Army. In fact, we have given more than our share in some instances. Just the other day the doctor from a village of 800, with a community, including the village, of some two to three thousand people, went into the Army, leaving the community without any doctor at all. A doctor 12 miles away will have to take care of that community until someone comes to take the place of the man who has gone. There are some other communities in the district where the only doctor has gone into the Army, which makes an additional burden upon the doctors who are left. The problem with us, as is the case probably in most places, is that the doctor is not looking for work, but is looking for time to do that which comes to him, and everybody is doing all he can, with few exceptions, and sorry he cannot do more in his service to the country. I do not think we shall have very much activity in our medical society work in any respect except that pertaining to the War, until the War is over.

PRESIDENT: The next district is the 12th, Dr. Hayes of Milwaukee.

DR. D. J. HAYES, Milwaukee: Mr. Chairman and Gentlemen: The number of members in the Society last year was 377. During the year we had 49 delinquents, 3 removals and 6 deaths, and there were 30 new members, so that we have a loss of 31 members for the year.

The meetings have been held in the county every month, and we have quite a large attendance, notwithstanding the number of men who are in the service, and the large number of men in the county who are engaged in war work. The meetings have been enthusiastic, and everything is moving along smoothly in the 12th District.

PRESIDENT: Gentlemen, you have heard the reports of all the councilors. Are there any remarks with reference to them? If not, the reports will be accepted as read.

We next come to the report of the treasurer, Dr. Hall?

The report of the treasurer was presented by Dr. S. S. Hall, Ripon, as follows:

TREASURER'S REPORT.

Milwaukee, Wis., October 1, 1918.

S. S. Hall, Treasurer, in account with the State Medical Society of Wisconsin.

DEBTOR.

Balance on hand Oct. 1, 1917	$3,850.02
Received from Secretary for County Dues	3,637.50
Total	$7,487.52

CREDITOR.

1917		
Oct. 6	Rock Sleyster—Expense Secretary	$ 34.43
	Henry Sullivan Engr. Co.—Expense Secretary	3.50

	Siekert & Baum Stat. Co.—Expense Secretary	1.47	
Oct. 10	—Hotel Wisconsin—Secretaries' Luncheon	17.25	
Oct. 15	—Dr. J. W. Nuzum—Expense Annual Meeting	10.00	
Oct. 27	—Dr. Kennon Dunham—Expense Annual Meeting	40.00	
Nov. 1	—Rock Sleyster—Expense Secretary	9.49	
	Waupun Democrat—Expense Secretary	3.00	
Nov. 8	—Cannon Printing Co.—Expense Secretary	18.00	
Dec. 3	—Rock Sleyster—Expense Secretary	6.42	
Dec. 31	—Rock Sleyster—Expense Secretary	6.64	$ 150.20
1918			
Jan. 2	—McDermott & Cowan—Stenographers	$ 294.20	
Jan. 22	—Dr. Frederick M. Allen—Expense	90.00	
Feb. 1	—Rock Sleyster—Expense Secretary	6.70	
	Siekert & Baum—Expense Secretary	1.75	
Feb. 8	—Volksfreund Publishing Co.—Expense Secretary	92.75	
Feb. 22	—H. E. Dearholt—Councilors' Luncheon	7.45	
Mar. 3	—Henry Sullivan Engr. Co.—Expense Secretary	3.60	
Mar. 5	—Siekert & Baum Stat. Co.—Expense Secretary	1.18	497.63
	Volksfreund Publishing Co.—Letter Heads, Officers	$ 27.47	
	Hoeder's Stationery Stores—Expense Secretary	2.57	
Apr. 2	—Rock Sleyster—Expense Secretary	27.63	
May 10	—Yawmwn & Erbe—Expense Secretary	2.07	
	J. P. McMahon—Expense, Wis. Med. Jour. Circulars	15.50	
	Siekert & Baum—Expense Secretary	3.29	
June 4	—Rock Sleyster—Expense Secretary	9.84	
	Wm. F. Zierath—Expense Councilors	8.19	
Aug. 12	—Henry Sullivan Engr. Co.—Expense Secretary	3.95	
Sept. 10	—Siekert & Baum—Expense Secretary	2.25	
Sept. 25	—Rock Sleyster—Expense Secretary	73.21	
	Waupun Leader—Expense Secretary	3.25	179.22
1917			
Dec. 31	—Rock Sleyster—Salary—Oct., Nov. and Dec.	$ 150.00	
1918			
Apr. 2	—Rock Sleyster—Salary—Jan. Feb. and March	150.00	
July 8	—Rock Sleyster—Salary—April, May and June	150.00	
Sept. 25	—Rock Sleyster—Salary—July, August and September	150.00	600.00
	S. S. Hall—Salary—Year 1917-1918	$ 200.00	
	S. S. Hall—Incidentals and Postage	20.00	220.00
Aug. 20	—J. P. McMahon—Wis. Med. Journal	$1,500.00	1,500.00
	Total		$3,147.05
	Balance		4,340.47
	Total		$7,487.52

Respectfully submitted,

S. S. Hall, *Treasurer.*

TREASURER'S REPORT.

MEDICAL DEFENSE FUND.

Milwaukee, Wis., Oct. 1, 1918.

S. S. Hall, Treasurer, in account with the State Medical Society of Wisconsin.

Debtor.

1917		
Oct. 1	—Balance on hand	$3,339.09
	Received from Secretary	2,962.50
	Total	$6,301.59

Creditor.

1917		
Oct. 11—Lines, Spooner & Quarles	$2,500.00	
1918		
Apr. 15—Lines, Spooner & Quarles	1,000.00	$3,500.00
Total		$3,500.00
Balance		2,801.59
Total		$6,301.59

Respectfully submitted,

S. S. HALL, *Treasurer.*

PRESIDENT: Gentlemen, you have heard the report of the treasurer. What is your pleasure?

DR. C. H. LEMON, Milwaukee: I move that the report be accepted as read.

Motion seconded.

DR. HERMAN REINEKING, Milwaukee: Isn't it necessary to have this report referred to an auditing committee?

PRESIDENT: The council will do that in the morning. The council is to audit the report.

DR. REINEKING: I second the motion of Dr. Lemon then that the report be received and placed on file.

Motion put and carried.

DR. S. S. HALL, Ripon: The council will appoint an auditing committee at its next meeting, to audit the secretary and treasurer's account.

There is one little explanation which I should like to make. You will notice that this report says, "paid to the Wisconsin Medical Journal $1,500" and the report of the Publication Committee says $1,515.50. That item of $15.50 was read in the report previous to the report of the payments to the Wisconsin Medical Journal, for the reason that that amount of money was for the expense of the Journal in putting some slips into the Journals that went out. It did not properly come in the money that was paid to the Journal.

PRESIDENT: We will now listen to the report of the secretary:

The report of the secretary was presented by Dr. Rock Sleyster, Waupun, as follows:

REPORT OF THE SECRETARY FOR THE PERIOD FROM JANUARY 1 TO OCTOBER 1, 1918.

To the House of Delegates of the State Medical Society of Wisconsin.

There was no change during the year 1917 in the number of component County Medical organizations. Fifty-four societies remitted for their members. A total number of 1856 paid dues for the year 1917. This is an increase of 29 over the previous year and is the largest recorded membership of the State Medical Society. This is 66 per cent of the licensed physicians of the state, probably 80 per cent of those engaged in active practice and about 95 per cent of those eligible for membership.

We retain our place as the best organized of the middle west states and still rank among the three or four best organized in the Union. No state having as large a number of physicians has a greater proportion as members of its state society.

The incomplete report for the year 1918 follows. It should be borne in mind that the data given is up to October second only, and that three months of the year still remain which will materially perfect conditions shown at this time. The data with which it is compared in the tables is for full years while this is for but a nine months' period. Tables are attached which show the 1917 membership complete and the 1918 membership to date, the losses or gains, the number of delinquents, the deaths, removals and new members for each County Society and each district in the state are given.

STATE MEDICAL SOCIETY OF WISCONSIN.

MEMBERSHIP REPORT.

October 1, 1918.

County Society.

1st District—	1917	1918	Loss—Gain+	Delinquent	Removals	Deaths	New Members
Dodge	32	32	0	0	0	0	0
Jefferson	30	30	0	1	0	0	1
Washington	19	16	—3	1	1	1	0
Waukesha	44	43	—1	3	0	0	2
	125	121	—4	5	1	1	3
2nd District—							
Kenosha	30	34	+4	1	0	0	2
Racine	38	46	+8	1	0	1	9
Walworth	28	28	0	2	0	0	2
	96	108	+12	4	0	1	13
3rd District.							
Dane	110	104	—6	4	5	0	2
Columbia	30	30	0	0	0	2	2
Green	19	20	+1	0	0	0	1
Rock	59	58	—1	3	0	1	2
Sauk	17	17	0	1	0	0	1
	235	229	—6	8	5	3	8

4th District—							
Crawford	8	6	—2	2	0	0	0
Grant	42	43	+1	0	2	0	1
Iowa	13	12	—1	1	1	0	0
La Fayette	18	20	+2	0	0	1	1
Richland	15	18	+3	0	0	0	3
	96	99	+3	3	3	1	5
5th District—							
Calumet	15	15	0	0	0	0	0
Manitowoc	32	33	+1	0	1	0	2
Ozaukee	10	10	0	0	0	0	0
Sheboygan	48	46	—2	3	0	0	1
	105	104	—1	3	1	0	3
6th District—							
Brown-Kewaunee	38	37	—1	4	0	0	0
Door	13	11	—2	1	0	1	0
Outagamie	37	38	+1	1	1	0	2
Fond du Lac	60	59	—1	1	1	1	1
Winnebago	55	41	—14	13	0	1	0
	203	186	—17	20	2	3	3
7th District—							
Juneau	12	10	—2	2	0	0	0
La Crosse	38	44	+6	0	2	0	7
Monroe	20	19	—1	0	0	1	0
Trempealeau-J.-B.	29	30	+1	0	1	0	2
Vernon	19	18	—1	2	0	0	1
	118	121	+3	4	3	1	10
8th District—							
Marinette-Flor.	22	22	0	0	2	0	2
Oconto	9	5	—4	5	0	0	0
Shawano	20	17	—3	4	0	0	1
	51	44	—7	9	2	0	3
9th District—							
Clark	18	12	—6	6	0	0	0
Green Lake-W.-A.	29	26	—3	3	0	0	0
Lincoln	13	15	+2	0	0	0	2
Marathon	36	31	—5	4	1	1	0
Portage	22	25	+3	1	0	1	4
Waupaca	29	29	0	0	0	0	0
Wood	25	24	—1	0	1	0	0
	172	162	—10	14	2	2	6
10th District—							
Barron-P.-W.-S.-B.	38	38	0	0	0	1	1
Chippewa	20	21	+1	1	0	0	2
Dunn-Pepin	21	17	—4	7	0	0	2
Eau Claire	31	30	—1	2	0	1	0
Pierce	11	7	—4	4	0	1	1
Rusk	8	9	+1	0	0	1	1
St. Croix	20	17	—3	3	1	0	0
	149	139	—10	17	1	4	7
11th District—							
Ashland-B.-I.	25	29	+4	1	1	0	5
Douglas	41	37	—4	1	2	1	0
Langlade	15	14	—1	2	0	0	0
Oneida-F.-V.	16	12	—4	6	0	0	2
Price-Taylor	12	16	+4	1	1	0	5
	109	108	—1	11	4	1	12
12th District—							
Milwaukee	377	360	—17	38	3	6	30
Total	1836	1794	—42	136	30	23	103

DIGEST OF TABLES.

Three districts show a gain—the 2nd, 12; the 4th, 3; and the 7th, 3.

Nine districts show a loss—the 1st, 4; the 3rd, 6; the 5th, 1; the 6th, 17; the 8th, 7; the 9th, 10; the 10th, 10; the 11th 1; the 12th, 17.

The 4th and 5th districts have 3 delinquents; the 2nd and 7th have 4; the 1st, 5; the 3rd, 8; the 8th, 9; the 11th, 11; the 9th, 14; the 10th, 17; the 6th, 20; the 12th, 38.

The 12th district has 30 new members; the 2nd, 13; the 11th, 12; the 7th, 10; the 3rd, 8; the 10th, 7; the 9th, 6; the 4th, 5; the 1st, 5th, 6th, 8th have 3.

Sixteen counties show a gain; 27 show a loss, and 10 remain the same.

The greatest gain is Racine, which shows a gain of 8; next is La Crosse with a gain of 6 and Kenosha, Ashland, Bayfield, Iron, and Price-Taylor Counties with a gain of 4 each.

The greatest loss is Milwaukee with a loss of 17; the next is Winnebago with a loss of 14; then Clark and Dane with 6 and Marathon with 5.

Eighteen counties have no delinquents. The following counties show the largest number of delinquents—Milwaukee, 38; Winnebago, 13; Dunn-Pepin, 7; and Clark and Oneida-Forest-Vilas with 6 each.

Thirty-two counties report 103 new members. Honors go to Milwaukee with 30 new members; Racine following with 9; La Crosse with 7; and Ashland-B.-I. and Price-Taylor with 5 each.

Total membership Dec. 31, 1915.....1791
Total membership Dec. 31, 1916.....1795
Total membership Dec. 31, 1917.....1836
Total membership Oct. 2, 1918.....1794

The number of delinquents for the year 1916 was 81; for 1917 it was 84 and for 1918 it is 136, but three months of the year still remain which will decrease that number greatly.

The deaths and removals for 1916 totaled 76; in 1917, 60 and in 1918, 53.

There were 107 new members in 1916; 143 in 1917 and 103 in 1918.

An analysis of the above shows that each year, in spite of every effort of the County and State secretaries, from 80 to 90 men fail to meet their financial obligations to the Society by the time of the State meeting. The losses to the State Society by deaths and removals

during the past year is somewhat less than usual. The number of new members is less this year than last as is our total membership, but the war has been a great factor in this and we still have three months remaining in which to bring our membership up to the standard.

REPORT ON ORGANIZATION.

The Secretary at the last meeting predicted in his annual report that we had then attained our maximum membership and expressed the belief that we would not again reach the 1800 mark. This belief was based on the knowledge of a constantly decreasing number of new physicians coming into the state, because of increased requirements for registration and the decreasing number of medical graduates due to the raising of standards in all of our medical schools.

The condition of the Society from an organization standpoint is quite as satisfactory this year as in 1917. There are but few physicians in the state who are eligible and desirable as members who are not affiliated with the organization. Notwithstanding the rapid falling off in the medical population and the disorganization which has resulted from the inroads made upon the profession due to the war, we are able to report at this time a paid up membership for 1918 numbering 1794. This is but 23 short of the number reported during the practically normal year which preceded our last meeting and is but 42 less than the total membership for 1917, with three months remaining in which a good share of this loss will be made up.

Those who are familiar with the shortage of physicians which exists at present, due to the causes enumerated, will readily appreciate that nothing can prevent a moderate but steady decline in our membership during the next few years. The matriculation in our medical schools during the war will be far less than in normal times, which means fewer graduates during a period when the greatest demands will be made upon the profession with no adequate supply to make up for the shortage already existing. The future will therefore require, if we are to maintain our present activities, the prompt and hearty co-operation of every member of the Society and it is quite possible that to maintain a program of progressive accomplishment our expenses will increase while we are facing a lessened income to a degree that will require raising the annual dues. We do not, however, anticipate that this will be necessary during the coming year.

STATE ACTIVITIES.

The reports of the various activities of your committees have been published in the Hand-Book mailed to you. The commiteee on Public Policy and Legislation has had little to do during the past year but the coming session of our state legislature will require constant attention to legislation affecting the profession.

The report of the Publication Committee shows the Journal to have been economically conducted. We feel keenly the loss of Dr. Warfield as editor of the Journal. This committee has seen fit to place this work in the hands of the state secretary and he will make every effort to keep the Journal up to the standard established by those who have preceded him.

Our committee on Social Insurance has conducted an exhaustive study of the subject and must be prepared to safeguard the profession when the proposed legislation is introduced at Madison this winter.

The committee on Health and Public Instruction has continued to send the Crusader to each member of the Society.

POST-GRADUATE MEDICAL TEACHING.

The organization work in connection with the post-graduate medical instruction of the University of Wisconsin has been conducted during the past year from your secretary's office. You will recall that this teaching was established as the result of a resolution passed by the 1916 House of Delegates and presented to the Regents of the University.

Drs. F. C. Rinker and H. P. Greeley of the University were engaged to do this teaching and have covered most of the larger places in the state, giving courses on "Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs" and "Diseases of Metabolism.

These courses have been both clinical and didactic and have usually covered a six day period. They have been given at a cost to the physician of from three to five dollars per course. Courses have been given at Fond du Lac, Oshkosh, Appleton, Marshfield, Wausau, La Crosse, Green Bay, Sheboygan, Janesville, Beloit, Superior and Eau Claire.

In addition to this teaching, the Bureau of Post-Graduate Medical Instruction has held itself ready to assist county societies by furnishing specialists for their programs. The Bureau has also purchased a complete set of anatomical models which are kept at the University and are available for teaching or study at any time. Societies and individual physicians are urged to make use of these. They are also available for public health teaching, for the use for training schools for nurses, etc.

The department is now making available through the medical museum at Washington and other agencies moving picture films on medical and public health subjects which may be had without rental and only by paying cost of transportation. Descriptive matter on these films and on the anatomical models will shortly be printed in the Journal and circulars will be issued for general distribution. It is hoped that this effort to bring medical teaching to the homes of our members will receive the cordial and whole-hearted support it deserves.

WAR CONDITIONS.

A report this year would indeed be incomplete without including a rather careful consideration of the tremendous responsibilities forced on the profession because of the war and the measures which have been taken to meet them. The Council of National Defense at Washington last year appointed a Wisconsin Committee, Medical Section, which was organized with Dr. Edward Evans of La Crosse as chairman, Dr. J. S. Evans of Madison

as vice-chairman and your state secretary as secretary. A little later, a State Council of Defense was created with Dr. J. S. Evans as the medical member and a state committee on War Activities of the State Society was appointed with the same members.

By keeping all of this war work assigned by different agencies in one committee, a confusion and duplication of effort has been avoided which exists in many other states because of several committees each endeavoring to do the same work. During the past summer, Dr. Edward Evans has left for Red Cross service in France and he has been succeeded by Dr. J. S. Evans. Auxiliary County Committees have been formed in each county of the state and have given splendid co-operation in the work asked of them.

Early in the year it was realized that the demands of the government would be such as to tax the profession to its limit and, unless carefully handled, seriously jeopardize the medical needs of the communities of the state. It was, therefore, decided to make a careful survey of our medical resources and a questionnaire was mailed to every physician in Wisconsin which covered his fitness for service, his domestic responsibilities and the needs of his community. The report he gave was verified to insure its accuracy.

In May, a meeting of the State Committee and representatives of the County Committees was held in Milwaukee under the group leadership of the Councilors of the State Society. The availability for service of each man was considered on the information furnished by himself and he was classified according to his availability. It has been the endeavor of the committee to encourage the enlistment of men who should go into the service because their communities and families can spare them and to protect the others from a constantly annoying series of indiscriminate invitations to join the colors.

We have been fairly successful in protecting our communities although there are at this time many of the smaller towns in the state which for years have had a medical practitioner and are now forced to send to neighboring cities or villages for medical help. In addition to this, many of the larger places have had their number of physicians decreased by half and more, while other larger towns well able to spare a number of medical men have not done their share.

A careful study of the state has been made and maps indicating the number of square miles in each community per physician and number of people per physician have been prepared. An exchange has been conducted in the secretary's office to which all physicians disqualified for service and willing to substitute in order to relieve some man for military duty have been invited to send in their names. By this means, we have many times been able to secure a practitioner for a community left without medical help and we have often been able to supply a disqualified man to take over the work of some man entering the service.

Throughout the year, Wisconsin has made a splendid response to the calls of the Surgeon General for enlistments in the Medical Reserve Corps. We have at all times stood in the first group of states and, density of population and population per physician considered, I think I can safely state that Wisconsin has not been surpassed. A checking of our records at this time shows that out of a medical population of 2814, 678 Wisconsin physicians have accepted commissions in some branch of the service and that 621 have been called into active service. This is 24.1 per cent of the entire number of physicians registered to practice in the state and means one out of every four in uniform today. It is probably one-third of the graduate physicians who were engaged in active practice at the beginning of the war and is certainly a half of those who, age and physical condition considered, are qualified.

A study of our survey at this date shows that three of our counties have given more than 40 per cent of their physicians to the service; that 18 counties have given from 30 to 40 per cent; that 16 counties have given from 25 to 30 per cent; that 9 counties have given 20 to 25 per cent; that 8 counties have given from 15 to 20 per cent; that 7 counties have given from 10 to 15 per cent and that 9 only have given less than 10 per cent.

A card index is kept in the secretary's office, giving the necessary data on every physician in Wisconsin. His classification as to availability is kept on this card as is the personal information he gave on his questionnaire together with the needs of his community. This index is corrected daily as is a survey of each of our counties. We have also prepared indexes of men engaged in special practice and any information of this sort desired by the Surgeon General or the Council of National Defense is instantly available. To keep this accurate and up to date, the secretary invites the co-operation of each member of the Society in keeping him informed of men removing, locating, or entering the service.

Maps which show much of the data we have on hand are attached to this report and will be on display at the Auditorium throughout the meeting.

We are, of course, unable to predict with any certainty what the demands of the Surgeon General will be during the coming year. We have been told that 15,000 more medical officers will be needed by the first of January, 1919. This means that Wisconsin's quota will be at least 300. We think that we can confidently assure the Surgeon General that Wisconsin will promptly meet its quota at all times and that the medical men at home stand ready to make the big sacrifice when their turn comes. I wish to urge upon you the debt of gratitude we owe the men who have volunteered for service. Provision should be made that the dependents they may leave will not want. We should in all ways safeguard their interests at home and keep intact as far as possible the practice they leave, that a resumption of same may be easy on their return. We may well be proud of the part our own Wisconsin medical men are playing in this great game to make this world of ours a fit place in which to live.

During the past year, your secretary has been required to sacrifice practically all of his personal interests for organization work. In addition to his duties as secretary, he has taken over the Journal, has planned the University Extension courses, has cared for the office

work in connection with the Council of Defense, recruiting physicians, examination of applicants for the Reserve Corps and the medical work in connection with the draft. He has covered almost the entire state twice during the past year. He has been impressed almost everywhere with the improvement in organization work, with the get-together spirit manifested and the development of a team work on the part of the profession which is needed now as never before.

In closing, he wishes to again remind the members that the activities of this organization are not confined to an annual meeting. We are working in your interests every day of the year. We may make mistakes but we ask your charity for these. We again ask your cooperation and assure you that this office is at your service, yours to use.

Respectfully submitted,

ROCK SLEYSTER,
Secretary.

PRESIDENT: I do not believe there is any necessity in taking a vote on a report of this sort. However, it is customary I think, and I would like to hear your pleasure in the matter.

DR. EDWARD QUICK, Milwaukee: I move you, Mr. President, that the report be accepted.

Motion seconded.

Motion put and carried.

PRESIDENT: We come now to the election of delegate and alternate to the American Medical Association, to succeed Dr. Horace M. Brown and Rock Sleyster, delegates, and W. E. Bannen and T. W. Nuzum, alternates. If I am not mistaken, two years ago the secretary was made a permanent delegate to the American Medical Association. That would leave only the name of Dr. Horace M. Brown to be considered.

SECRETARY: The House of Delegates voted to make the Secretary a permanent delegate, but that was unconstitutional. The constitution of the American Medical Association requires that delegates be elected every two years.

PRESIDENT: The constitution of the American Medical Association does not prohibit that one man be reelected, does it?

SECRETARY: No.

DR. HERMAN REINEKING, Milwaukee: I nominate Dr. Rock Sleyster, our present secretary.

Nomination seconded.

PRESIDENT: Dr. Rock Sleyster is nominated as delegate to the American Medical Association.

DR. C. H. LEMON, Milwaukee: Mr. Chairman, I rise to nominate Dr. Horace M. Brown to succeed himself. I should like to say to the House of Delegates that there were two very strong delegations sent to the American Medical Association this last year. The personnel of those delegations was so striking that I think that they referred to them at this time. They were the delegations from the state of New York and from the state of Pennsylvania. Tomorrow you will see in Major McLean, of the Surgeon General's office, one of the delegates from the state of Pennsylvania, and although he is a very handsome fellow and a very forceful speaker, he hardly excelled others from his state delegation.

In rising to nominate Dr. Brown, I feel that we sort of owe a debt of gratitude to Dr. Brown for what he did a year ago in saving to the state of Wisconsin and to this Society, Dr. Sarles as a member of the board of directors of the American Medical Association. A man who sits for only two years in the House of Delegates hardly gets acquainted, and Dr. Brown made a very favorable impression this last year, being the first year I sat as delegate, and I think he enjoyed the work very much, because he said that he recognized the fact he was getting to be an old chap and sort of passé, that he did hope, or at least that he would like to be re-elected. And I know of no man in the state of Wisconsin who is more popular with the profession, or who can make a better impression before the delegates in the House of Delegates of the American Medical Association, than Dr. Brown. I therefore, urge his nomination and election at this time.

Nomination seconded.

PRESIDENT: Are there other nominations? If not, it has been moved and seconded that Dr. Horace M. Brown, and Dr. Rock Sleyster be elected to succeed themselves as delegates to the American Medical Association. All in favor of this motion will signify it by saying "aye," opposed "no."

Motion unanimously carried.

PRESIDENT: They are declared elected. Now as to the alternates, to succeed Dr. W. E. Bannen and Dr. T. W. Nuzum. What is your pleasure?

DR. D. J. HAYES, Milwaukee: I nominate Dr. Pember of Janesville, as one of the delegates.

Nomination seconded.

PRESIDENT: Are there other nominations? There are two alternates to be selected.

DR. JOSEPH SMITH, Wausau: I nominate Dr. Lemon.

DR. C. H. LEMON, Milwaukee: I am already a member, thank you.

DR. FRANZ PFISTER, Milwaukee: I nominate Dr. Jermain.

Nomination seconded.

PRESIDENT: Dr. Jermain has been nominated. Are there other nominations? Who else wants to go? Dr. Pember of Janesville, and Dr. Jermain of Milwaukee, have been nominated as alternates to the American Medical Association.

DR. W. J. RAGAN, Shawano: I nominate Dr. Redelings of Marinette.

Nomination seconded.

PRESIDENT: Are there other nominations? That makes three.

DR. EDWARD QUICK, Milwaukee: Should there be two or three alternates?

PRESIDENT: Two alternates.

DR. T. J. REDELINGS, Marinette: Mr. Chairman, I would respectfully withdraw my name, and move that we proceed to ballot for Dr. Jermain and Dr. Pember.

DR. QUICK, Milwaukee: I second the motion.

PRESIDENT: Is Dr. Ragan, who nominated Dr. Redelings, satisfied?

DR. RAGAN: I am satisfied.

PRESIDENT: It has been moved and seconded that Dr. Redelings name be withdrawn and a vote be taken on the names of Dr. Pember of Janesville, and Dr. Jermain of Milwaukee. All in favor will signify by saying "aye"; opposed, "no."

Motion carried unanimously.

PRESIDENT: Now will someone make a motion to have those two men elected as alternates.

DR. D. J. HAYES, Milwaukee: Mr. President, I move you that they be elected as alternates.

Motion seconded.

Motion put and unanimously carried.

PRESIDENT: The next business is the election of councilors to succeed F. T. Nye, in the 3rd District, and Wilson Cunningham, in the 4th District.

DR. J. F. PEMBER, Janesville: I move the election of Dr. F. T. Nye to succeed himself as councilor of the 3rd District.

Motion seconded.

PRESIDENT: Are there other nominations? If not, the motion is that Dr. F. T. Nye, of Beloit, be elected to succeed himself as councilor of the 3rd District. All in favor will signify by saying "aye"; opposed, "no."

Motion carried unanimously.

DR. JOSEPH SMITH, Wausau: I nominate Dr. Cunningham to succeed himself as councilor in the 4th District.

Nomination seconded.

PRESIDENT: Dr. Cunningham has been nominated to succeed himself as councilor of the 4th District. Are there other nominations? If not, all those in favor of the election of Dr. Cunningham to succeed himself as councilor of the 4th District will signify by saying "aye"; opposed, "no."

Motion unanimously carried.

PRESIDENT: We now have a councilor for the 7th District, who is absent in France, and he has selected Dr. Sarles of Sparta to do the work for him while he is away. I think it will meet the approval of the House of Delegates that Dr. Sarles continue to do the work for Dr. Evans, or shall we select another councilor? Do I hear any motion to that effect?

DR. G. J. EGAN, La Crosse: Mr. President, I move that Dr. Sarles be nominated for the 7th District.

PRESIDENT: To act until Dr. Evans returns?

DR. EGAN: Yes.

Motion seconded.

Motion put and unanimously carried.

PRESIDENT: The next number on the program is the election of committees and delegates as follows: Committee on Public Policy and Legislation; Committee on Medical Education; Delegate to National Legislative Council to succeed G. Windesheim; delegates to Council on Medical Education to succeed L. M. Warfield; Member of Committee on Health and Public Instruction to succeed J. M. Beffel; Committee on Publication, and Committee on Medical Defense.

This House of Delegates has sometimes taken it upon itself to select by vote from the floor these different committees and delegates, and sometimes this selection has been left to the Nominating Committee. Our constitution and by-laws does not specify in which way these committees or delegates should be selected, or whether the Nominating Committee has any right to make nominations of that kind. It would not have any right to do so unless the House of Delegates gives it that right.

DR. H. W. ABRAHAM, Appleton: I move you, Mr. President, that this matter be left to the Nominating Committee.

Motion seconded.

PRESIDENT: It has been moved and seconded that the nominating of these different committees be left to the Nominating Committee. Are there any remarks?

DR. HERMAN REINEKING, Milwaukee: Mr. President and Gentlemen: It seems to me that it would be advantageous to select the members of the committees from the floor now, for this reason. It would be impossible for a committee, at a meeting held outside of the general meeting, to ascertain which of the members will be able to serve. If the members are picked out here tonight they can express themselves as to whether they will be able and willing to serve or not; otherwise the Nominating Committee will have to make its selection without ascertaining this, and the matter cannot be decided until Thursday morning's meeting, when the report is brought in, at which time there will be very little opportunity to select other men in place of those nominated who will be unable to serve. It is necessary

to know at the time when the nominations are made, whether the men can and will serve.

PRESIDENT: Are there any further remarks on the motion? Gentlemen, that remark coming from a member of the Nominating Committee, I think has some weight.

DR. D. J. HAYES, Milwaukee: Mr. President and Gentlemen: I agree fully with what Dr. Reineking has said. I remember when I was on the Nominating Committee of the Society some years ago, the most difficult part of our work was to ascertain this very information, and I think this is a matter that should be left to the body itself, and not given to the Nominating Committee. They are not able to determine who will serve on the committees.

PRESIDENT: Are there further remarks? The motion is to leave the selection of those committees to the Nominating Committee. You have heard the few remarks opposing that motion; are there any other remarks, or are you ready for the question?

DR. S. S. HALL, Ripon: Mr. President, what does the constitution say with reference to the appointment?

PRESIDENT: Nothing whatever. The constitution says that the House of Delegates shall select those committees.

DR. S. S. HALL: The House of Delegates. Then why not do it?

PRESIDENT: But the House of Delegates has referred the matter several times to the Nominating Committee.

DR. S. S. HALL, Ripon: How can they refer a matter that is their province?

PRESIDENT: The House of Delegates has the right to refer it to the Nominating Committee, and then to select them after the Nominating Committee has made the nominations. This is simply the nomination by those committees.

DR. D. J. HAYES, Milwaukee: Mr. President, I move that you amend the doctor's motion by placing it before the House.

PRESIDENT: Vote it down if you do not want it.

(Calls for the question.)

Motion put.

PRESIDENT: I will take a rising vote. All in favor of leaving the selection of those committees, or at least the nomination of the members of those committees to the Nominating Committee, will stand up.

The vote in favor stood 13.

PRESIDENT: All opposed, rise.

The vote in opposition stood 20.

PRESIDENT: The opposition has it. Proceed with the nomination of your Committee on Public Policy and Legislation.

DR. JOSEPH SMITH, Wausau: I nominate the present committee, consisting of Dr. Edward Quick, Milwaukee, Dr. J. P. McMahon, Milwaukee, and Dr. L. H. Prince, Madison, and move their election.

Motion seconded.

PRESIDENT: You have heard the motion. Are there other nominations? If not, the nominations are declared closed.

All in favor of the motion that Dr. Edward Quick, Dr. J. P. McMahon, and Dr. L. H. Prince shall be elected as the Committee on Public Policy and Legislation, will signify by saying "aye"; opposed "no."

Motion carried unanimously.

PRESIDENT: They are declared elected. We will now proceed to the election of the Committee on Medical Education.

DR. D. J. HAYES: Who is on that committee?

PRESIDENT: The present members of the committee are Dr. L. F. Jermain, Milwaukee, Dr. J. Van De Erve, Milwaukee, and Dr. C. R. Bardeen, of Madison.

DR. C. H. LEMON, Milwaukee: I move you, Mr. President, that they be nominated and elected to succeed themselves.

Motion seconded.

PRESIDENT: Are there any other nominations?

(Calls for the question.)

Motion put and unanimously carried.

PRESIDENT: The next matter before the House of Delegates is the nomination and election of delegate to National Legislative Council. Gentlemen, there is no such thing as a National Legislative Council. For the last 2 or 3 years there has been selected by this House of Delegates a delegate to the National Legislative Council, which does not exist. It really is the Council on Public Policy, I think. They usually send me a notice to appear there, and I generally go there. Last year they did not have any meeting. However, Major Sleyster persists in calling it the National Legislative Council.

DR. H. W. ABRAHAM, Appleton: I move you that the present member of that committee, Dr. Windesheim, be elected to succeed himself.

Motion seconded.

Motion put and unanimously carried.

PRESIDENT: The next thing in order is the election of a delegate to the Council on Medical Education, of the American Medical Association, to succeed Dr. L. M. Warfield.

DR. JOSEPH SMITH, Wausau: Inasmuch as Dr. Warfield will probably be in the War Service during the coming year, I would nominate Dr. Jermain as such delegate, and move his election.

Motion seconded.

PRESIDENT: Are there other nominations? If not, Dr. Jermain has been nominated as the delegate to the Council on Medical Education to succeed Dr. L. M. Warfield, of Milwaukee. All in favor of his selection will signify by saying "aye"; opposed, "no."

Motion unanimously carried.

PRESIDENT: Next in order is the selection of a member of the Committee on Health and Public Instruction to succeed Dr. J. M. Beffel.

DR. W. H. PARKE, Glenwood: I place in nomination Dr. W. H. Washburn, of Milwaukee, and move his election.

PRESIDENT: The name of W. H. Washburn, of Milwaukee, has been placed in nomination. Are there further nominations? If not, all in favor of the election of Dr. W. H. Washburn to succeed Dr. Beffel as a member of the Committee on Health and Public Instruction, will signify by saying "aye". opposed, "no."

Motion unanimously carried.

PRESIDENT: The next thing on the program is the election of the Committee on Publication. This committee is at present composed of Dr. A. J. Patek, of Milwaukee, Dr. G. E. Seaman, O. H. Foerster, Rock Sleyster, and S. S. Hall.

DR. A. J. PATEK, Milwaukee: Mr. President, several members of that committee either now are or will soon be in the Service. Dr. Seaman is now in Service; Dr. Foerster left, I think, today, and I expect to leave in the course of this month. I think it unfair to the Society that the officer members of the committee be away from their posts of duty, and I suggest that others be elected to fill the vacancies created by the absence of these members, and their inability, in consequence, to serve.

DR. HERMAN REINEKING, Milwaukee: I nominate Dr. Oscar Lotz as one of the committee.

Nomination seconded.

DR. C. H. LEMON, Milwaukee: I nominate Dr. Sleyster to succeed himself.

SECRETARY: The constitution provides that the secretary and treasurer are ex-officio members.

DR. LEMON: Then there are only 3 members to be elected. I nominate Dr. H. E. Dearholt.

Nomination seconded.

(The name of Dr. L. F. Jermain, from Milwaukee, was placed in nomination, but on request of Dr. Jermain, with the consent of the nominator, his nomination was withdrawn.)

DR. A. J. PATEK, Milwaukee: I nominate Dr. Joseph Smith, of Wausau.

Nomination seconded.

PRESIDENT: Dr. Sleyster and Dr. Hall are ex-officio members of that committee. We now have the names of Dr. Oscar Lotz, Dr. H. E. Dearholt, and Dr. Joseph Smith of Wausau, in nomination. Are there further nominations?

Motion made that the nominations be declared closed, and that Dr. Oscar Lotz, Dr. H. E. Dearholt and Dr. Joseph E. Smith be elected as members of the Publication Committee.

Motion seconded.

Motion put and unanimously carried.

PRESIDENT: The next in order is the election of the Committee on Medical Defense. The present members of the committee are Dr. G. E. Seaman, Milwaukee, Dr. A. J. Patek, Milwaukee, and Dr. S. S. Hall, Ripon.

DR. A. J. PATEK, Milwaukee: May I rise again to make the same objection to the re-election of that committee as at present constituted, if that be the intention. The same situation arises as in the previous instance. Dr. Seaman is away, and I expect to be away. The work of this committee is such that it is absolutely essential that at least the majority of the members be on hand. The work of Dr. Hall is that of the financial department, and my work has been that of assisting in the correspondence with those who apply for defense, advising with these defendants, and arranging conferences with our attorney. Inasmuch as most of the requests for defense have come to me through the secretary, who O'K's the applicant's right to protection, I believe that the secretary ought to be one member of that committee perhaps even its secretary; in other words, the active member of it. The work is not particularly onerous, and I would be the last one to add further burdens to those that the secretary has taken upon himself. I shall be glad to turn over to him, or to whoever shall be appointed, all the records that I have.

I therefore recommend and nominate Dr. Sleyster to be a member of that committee.

SECRETARY: Dr. Patek, I feel that I can serve just as well in that capacity as Secretary of the Society. I really feel that those two members of the committee should reside in Milwaukee, where they can get in touch with the attorney. In a good many of those cases it is necessary to take the matter up personally with Mr. Spooner, and it is a very easy matter for me to refer these requests on to the Milwaukee member, and he get in personal touch with the attorney in a way which I cannot do, living at Waupun. With your permission I would like to withdraw my name, and suggest the nomination of two Milwaukee men for that committee. I do not want to shirk any responsibility the Society wishes to put on me, and I really feel that Dr. Patek knows more about the subject than I do, but at the same time I do not believe he thought of that phase of it.

DR. PATEK: No, I had not thought of that. As a matter of fact it is true that very many of the men who apply, come to Milwaukee to confer with me and with

Mr. Spooner. Possibly it may be a better plan to have the secretary of that committee a resident of this city. I withdraw my nomination of Dr. Sleyster.

Dr. H. W. Abraham, Appleton: I nominate Dr. Quick.

Dr. Edward Quick, Milwaukee: I wish to withdraw my name. The work of the Committee on Public Policy and Legislation will keep me quite busy for the next year.

Dr. D. J. Hayes, Milwaukee: I nominate Dr. Reineking.

Dr. Franz Pfister, Milwaukee: I nominate Dr. Lemon.

Dr. Joseph Smith, Wausau: I second both nominations.

President: Dr. Abraham, do you withdraw Dr. Quick's nomination?

Dr. Abraham: I will withdraw the nomination if he refuses to run for the office.

President: That leaves Dr. Reineking and Dr. Lemon. Are there any other nominations? Dr. Hall is ex-officio a member of this committee, so there are only two to be selected.

Dr. A. J. Patek, Milwaukee: Mr. President and Gentlemen: It has been whispered here within a hundred feet of me that all on that committee are surgeons. Now it may not be any more than right, if a poor medical man were to be used, that there be a medical man on that committee. There is one such in this room, a resident of Milwaukee, who has been very active, and who is always willing to take added burdens, and he may be willing to assume another now, if the Society sees fit to put it upon his shoulders. I should like to nominate Dr. Lotz as a member of this committee.

President: The names of Dr. Reineking, Dr. Lemon and Dr. Lotz have been placed in nomination. Are there other nominations?

Dr. C. H. Lemon, Milwaukee: Mr. Chairman, as the surgeons are predominant on that committee, I would like to withdraw my name, because I think there is something in what Dr. Patek has said. Dr. Reineking is a few years my senior, and is well known throughout the state, and knows all the people who would be liable to be in trouble, and I therefore suggest that I be permitted to withdraw my name in favor of Dr. Lotz.

Dr. Herman Reineking, Milwaukee: All the remarks of Dr. Lemon apply to him as well as they do to me. I do not think the seniority amounts to much, or at any rate that it is of any importance, so I think I can return the compliments in every particular.

President: Does the doctor who nominated Dr. Lemon consent to the withdrawal of his name?

Dr. Pfister: No, sir.

Dr. H. E. Dearholt, Milwaukee: In adopting the report of the special committee on Medical Defense investigation, we adopted the concluding paragraph, which reads: "Your committee therefore, recommends that medical defense as conducted in the past, be continued, and that if the Society deem it wise to clothe its Defense Committee with discretionary powers this committee be enlarged so as to include one or more representatives of rural general practice."

I think that that suggestion of possibly enlarging the committee is a very good one, and inasmuch as we have adopted this committee's report, which has given careful consideration to the subject, I think that matter should be taken into consideration at this time.

President: Would it meet the pleasure of the House of Delegates to take that matter into consideration at the present time, that is, the enlargement of the committee on Medical Defense, before you select the members for that committee?

Dr. H. W. Abraham, Appleton: Mr. President, I move that the suggestion of this committee be adopted by the House.

President: The suggestion has been adopted, but action has not been taken as yet.

Dr. Abraham: I move then that two men from rural districts be added to this committee.

Motion seconded.

Motion put and unanimously carried.

President: The Committee on Medical Defense from now on shall consist of five members. We have at the present time the nomination of Dr. Reineking, and of Dr. Lemon, and that of Dr. Lotz.

Dr. Franz Pfister, Milwaukee: I nominate Dr. A. E. Bachhubber of Mayville.

Nomination seconded.

President: That makes 3 members from the city, and one from the rural districts.

Dr. F. S. Keech, Racine: I nominate Dr. R. W. McCracken of Union Grove.

Secretary: While nominations are on for this choice of rural members, I would like to call the attention of the House to the fact (and I believe Dr. Jermain will bear me out in this statement) that in the work of getting out his report, Dr. F. P. Knauf, of Kiel, Wisconsin, made a very careful study of the subject, and sent questionnaires to all of the other state societies, and to the different county societies in the state, and did a great deal of work in preparing this report, and studying the question.

Dr. Oscar Lotz, Milwaukee: I nominate Dr. Knauf, of Kiel.

Nomination seconded.

PRESIDENT: Are there further nominations? We now have the nominations of six members, one to succeed Dr. Seaman, one to succeed Dr. Patek, and two new members to be selected, and Dr. Cunningham, Dr. Lotz, Dr. Bachhubber, of Mayville, Dr. McCracken, of Union Grove, and Dr. F. P. Knauf, of Kiel. Dr. Jermain and Dr. Abraham will kindly act as tellers.

DR. A. J. PATEK, Milwaukee: Ought there not be two sets of three each? That would allow for the two rural members as suggested by this committee, and the two city members.

PRESIDENT: You mean take two votes?

DR. PATEK: Two Milwaukee men, and two out of the three for the other districts.

PRESIDENT: It has been suggested that you vote for two Milwaukee men and two rural men.

(Voting proceeded.)

DR. H. E. DEARHOLT, Milwaukee: There is one other matter in connection with this committee's report. You will notice in the last paragraph the suggestion of the possibility of giving to this Defense Committee discretionary power. We have adopted the report, but we have not acted on that recommendation.

I move you that the committee be given discretionary power in determining what cases shall and shall not be defended.

Motion seconded.

PRESIDENT: Are there any remarks on this question?

DR. T. J. REDELINGS, Marinette: Mr. Chairman, is it possible to grant such discretion to this committee? I ask this in all sincerity. I believe that members have equal rights. When we admit a man into this Society he is granted all the rights and covenants that go with membership, and if he is unfortunate enough, or whatever the cause, be it negligence, incompetence, viciousness, or what it may be, he is entitled to the protection which this Society offers, regardless, if his membership is good. I have no word in defense of the incompetent or reckless or indifferent or the vicious, but if his claim comes within the provisions of our constitution and the acts upon which this fund is founded, that man is entitled to defense by this Society, regardless of that committee. And while I would personally like to see this power granted to said committee, it seems to me that it is utterly impossible to grant such authority to a committee. I make these remarks simply to bring out the thought of the members present with reference to the matter.

DR. A. E. BACHHUBBER, Mayville: At a meeting of the Dodge Co. Society last week, which was to report to the committee, about 20 members present at the meeting unanimously voted not to give the committee that discretionary power. I think that is about the feeling of the profession at large, at least the rural part of it.

DR. T. E. PETERSON, Waukesha: As I look at it, it is the duty of the individual county society to see that the personnel of the society is right, and worthy of confidence and trust, and worthy of the protection and the benefits of the State Society and the National Society.

DR. REDELINGS: I think I recall distinctly that no provision is made to protect a man who is criminally guilty, neither by this Society or any insurance. A man who is guilty of a criminal act comes under a different jurisdiction entirely.

PRESIDENT: Are there further remarks on the subject?

(Calls for the question.)

DR. FRANZ PFISTER, Milwaukee: What is the question, please?

PRESIDENT: The question is with reference to giving this committee more discretionary power. The remarks that we have had on the subject, have all been opposed to that. All in favor of the motion as originally presented will signify by saying "aye"; those opposed, "no."

The motion is lost.

PRESIDENT: Gentlemen, of the votes cast for the members in the city, Dr. Lotz has received 22 votes, Dr. Reineking 18 votes, and Dr. Lemon 10 votes.

Of the rural members, as you might call them, the members from out of the city, Dr. Knauf received 22 votes, Dr. McCracken and Dr. Bachhubber each received 17. According to this vote the majority of the votes have been cast for Drs. Lotz and Reineking, for Milwaukee, Dr. Knauf for outside of Milwaukee, and it remains to draw straws between Dr. Bachhubber and Dr. McCracken. What is your pleasure?

DR. T. J. REDELINGS, Marinette: Isn't it in the power of the president to cast the deciding vote in any of these matters?

PRESIDENT: It is a ticklish job in this case, because one of these men is my personal friend, and it would not look well.

DR. REDELINGS: Please your personal friend, and do something for him.

PRESIDENT: It would not look well if I voted for him.

DR. S. S. HALL, Ripon: Is the other your enemy?

PRESIDENT: Not at all, but one is a close friend, and it would not look well if I voted either for him or against him.

DR. C. A. FIDLER, Milwaukee: Draw straws.

MEMBER: Flip a coin.

MEMBER: Make the secretary draw straws.

PRESIDENT: Doctor, you prepare straws, and let the secretary draw.

DR. S. S. HALL, Ripon: I do not believe there is anything in the constitution that provides for drawing straws.

PRESIDENT: It does.

DR. HALL: I never saw it. I know the president knows more about the constitution than anybody else.

PRESIDENT: It gives the president power to do just as he likes.

DR. HALL: Isn't it customary when you have a tie vote, and the president does not want to vote, to take another ballot?

PRESIDENT: That is the correct proceeding. Do you want to take another ballot?

DR. HERMAN REINEKING, Milwaukee: Mr. President, I think it would be well to be careful in the matter of electing this committee, because this committee will have to disburse funds, and should be legally elected.

PRESIDENT: Yes.

DR. HALL: You cannot legally elect them by a straw.

DR. C. H. LEMON: I move that the secretary cast the ballot of the House of Delegates for Dr. Bachhubber.

Motion seconded.

PRESIDENT: It has been moved and seconded that the secretary cast the vote for Dr. Bachhubber. All in favor will signify it by saying "aye"; opposed, "no." The ayes have it.

DR. S. S. HALL, Ripon: It seems to me a motion of that kind must be unanimous, according to parliamentary rule.

DR. LEMON: That is right.

DR. A. J. PATEK, Milwaukee: I move that we proceed to ballot for the missing member on this committee.

PRESIDENT: Distribute the ballots.

(Ballots were distributed by the tellers, and vote taken.)

PRESIDENT: Gentlemen, of the votes cast Dr. Bachhubber has received 17 and Dr. McCracken 11. Evidently Dr. Bachhubber's friends have stuck to him, and some of Dr. McCracken's friends have dropped off. According to this vote Dr. Bachhubber having received the majority of votes, is elected as a member of the Medical Defense Committee.

Now there is another committee which was oppointed during the present year. The request was made by the American Medical Association to appoint a committee on Hospital Standardization. The provisional appointments on that committee were Dr. L. F. Jermain, Milwaukee, Dr. L. E. Fazen, Racine, Dr. F. S. Wiley, Fond du Lac, Dr. J. V. R. Lyman, of Eau Claire, and Dr. F. G. Connell, of Oshkosh. This appointment has been a temporary one to serve until this House of Delegates should select another committee in its place. What is your pleasure?

DR. J. F. PEMBER, Janesville: I move that the same committee be continued.

Motion seconded.

Motion put and unanimously carried.

PRESIDENT: There is another committee, and that is the old hold-over committee on Constitution and By-Laws. This committee has finally, as it thinks, finished its work. The last report was made to the House of Delegates last year, was accepted by the House of Delegates, but the committee has not been discharged because the copies of the constitution and by-laws, as amended, and as the committee had had them amended, have not yet been printed, but Dr. Sleyster—Major Sleyster, tells me they are in the hands of the printer; is that right?

SECRETARY: No, they are not in the hands of the printer; they are being prepared for the printer; they will be there very shortly.

PRESIDENT: Being the chairman of that committee, I should like to have you discharge the committee and trust Dr. Sleyster to have the constitution and by-laws printed and distributed in due time.

DR. C. H. LEMON, Milwaukee: Mr. President, that committee should be a standing committee of this House.

PRESIDENT: All right.

SECRETARY: Dr. Windesheim is the committee anyhow.

DR. LEMON: I move you, Mr. Chairman, that the committee be continued.

Motion seconded.

PRESIDENT: Do you mean to have that committee made a standing committee?

DR. LEMON: Yes, sir.

PRESIDENT: That would mean adding one more standing committee.

DR. LEMON: There should be a standing committee on constitution and by-laws, to whom matters could be referred involving the constitution and by-laws.

PRESIDENT: In order to do that properly you will have to bring in an amendment to the constitution and by-laws creating that standing committee, at the meeting tomorrow, and it can be voted on the next day. Is that the pleasure of the House? Do you want to act on the question of this committee tonight, or do you want to postpone action until you hear further from Dr. Lemon, who is making the suggestion?

DR. LEMON: Why cannot that amendment be introduced tonight?

PRESIDENT: It can be introduced tonight in writing, but it cannot be voted on until tomorrow.

DR. LEMON: I will put that amendment in writing for you to vote on, or will ask the secretary to put it in writing.

PRESIDENT: Then we will postpone action on that committee until we hear further on the subject.

PRESIDENT: Is there any miscellaneous or new business to come before the House? If not, a motion to adjourn is in order. The House of Delegates will meet tomorrow morning at 8:30 at the Auditorium.

Motion made, seconded and carried to adjourn until 8:30 a. m. next day.

HOUSE OF DELEGATES.

SESSION HELD AT THE AUDITORIUM, MILWAUKEE. WEDNESDAY, OCT. 2nd, 1918,

8:45 A. M.

Meeting called to order by the president.

Roll call.

PRESIDENT: Delegates that did not register yesterday or whose names have not been called, will please give their names to the secretary.

The minutes of the last meeting were read by the secretary.

PRESIDENT: Gentlemen, you have heard the reading of the minutes of the last meeting. Are there any remarks or alterations, or corrections in regard to the minutes? If not, the minutes will stand approved as read. They are so approved.

We still have the reports of the councilors from the 4th District, Dr. Cunningham, and of the 5th District, Dr. Zierath.

The report of the councilor from the 5th District was presented by Dr. W. F. Zierath, Sheboygan, as follows:

Mr. Chairman and Gentlemen: The situation in the 5th District is very good. Last year we had a total of 105 members, and this year 103. There is a delinquency of 4 in Sheboygan County, but 3 of those men paid their dues last week, so there will be a net gain of one. The scientific work has not been up to the usual standard, due probably to the war situation.

PRESIDENT: We still have the reports of the councilors from the 7th and 10th Districts. Dr. Sarles is councilor in the 7th District, and Dr. Cairns in the 10th District. Neither of them is present.

Is there any new or miscellaneous business to be brought before the House of Delegates this morning?

SECRETARY: Nothing except this amendment to the by-laws.

PRESIDENT: The amendment to the by-laws having been presented at a previous meeting in writing, may be acted on at the present time. What is your pleasure?

DR. HERMAN REINEKING, Milwaukee: In order to bring the matter before the House, I move the adoption of the amendment.

Motion seconded.

PRESIDENT: It has been moved and seconded that the amendment to the by-laws as presented in writing last night, be adopted. Are there any remarks?

DR. H. E. DEARHOLT, Milwaukee: Mr. Chairman, I fail to see why a standing committee on constitution and by-laws is required any more than a very large number of standing committees that we could think of. We have standing committees at the present time that have been continued for years, and yet have never been made constitutional standing committees. It seems to me that inasmuch as the work of the Committee on Constitution and By-Laws has been completed, and all that they were called upon to do has been done, that there is no call to make it a standing committee. I am perfectly agreeable to the suggestion of continuing the committee for such action as may be desired from time to time, but see no reason for giving it the permanence of a standing committee.

PRESIDENT: Are there further remarks on this subject?

DR. HERMAN REINEKING, Milwaukee: I made the motion merely to bring the matter before the House, not that it would be understood as in any way wishing to promote it.

PRESIDENT: We understand your action, Doctor, was to bring the matter up for discussion. It seems to me that it is a question that should not be passed over lightly. It does not seem as if it were an important matter to have another standing committee, but we have a number of standing committees, and whether it is necessary, or even advisable to add that committee to the number of standing committees is one question; whether that committee would have anything at all to do for the next 2 or 3 years, is another question. That committee could never have the power to change the constitution and by-laws without the action of the House of Delegates, and that committee would have to be given some kind of power. It might be given the power to recommend changes in the constitution and by-laws, but that same power exists at the present time in any member of the House of Delegates. Any member of the House of Delegates that seems to think the constitution or by-laws ought to be changed or amended in any way has the right to bring in a recommendation in writing. So I personally cannot see even the advisability of having that committee as a standing committee. However, I would like to have an expression of some more of the members on the subject.

(Calls for the question.)

PRESIDENT: It has been moved and seconded that the amendment to the by-laws presented last night, constituting a committee on constitution and by-laws as a standing committee of this Society, should be accepted. All those in favor of this will signify by saying "aye"; opposed, "no."

Motion lost.

PRESIDENT: The motion is lost. Thank you, Gentlemen, for your vote. Is there any other question to come before the House of Delegates this morning? If not, a motion to adjourn will be in order.

Dr. Herman Reineking: I move that the House of Delegates adjourn to meet at 8:30 a. m. Thursday morning.

Motion seconded.

Motion put and carried.

Adjourned to Oct. 3rd, 1918.

HOUSE OF DELEGATES.

SESSION OCTOBER 3rd, 1918, 8:30 A. M., AT THE AUDITORIUM MILWAUKEE, WISCONSIN.

(Thursday.)

Meeting called to order by the President.

Roll call.

Minutes of last meeting read.

President: You have heard the reading of the minutes of the last meeting. Are there any alterations or corrections? If not, the minutes will stand approved as read. So approved.

The next thing on the program for this morning is the report of the Nominating Committee.

The report of the Nominating Committee was presented by Dr. Herman Reineking, Milwaukee, as follows:

Mr. President and Gentlemen: The Nominating Committee reports the following nominations, which were unanimously made:

For President, Dr. D. J. Hayes, Milwaukee.
For 1st Vice-President, Dr. J. S. Keech, Racine.
For 2nd Vice-President, L. A. Potter, Superior.
For 3rd Vice-President, Herman Gilbert, Madison.

President: Gentlemen, you have heard the report of the Nominating Committee. What is your pleasure?

Dr. S. S. Hall, Ripon: I move that the report be adopted.

Motion seconded.

Motion put and unanimously carried.

President: The report of the Nominating Committee is adopted, and the men as nominated are elected to office.

We still have the report of some of the councilors. The councilor of the 4th District has not reported as yet, and the councilor of the 7th District has not reported as yet.

Secretary: I have a letter from Dr. Sarles, saying that he will be unable to be here.

President: The councilor from the 10th District has not reported as yet.

There are still some matters to come up before the House of Delegates. One is the report of the Auditing Committee. The Auditing Committee was selected by the council last night to audit the accounts of the treasurer.

The report of the Auditing Committee was presented by Dr. Joseph Smith, Wausau, as follows:

Mr. Chairman and Gentlemen: The Auditing Committee has audited the accounts of the treasurer and secretary and finds them correct.

President: That is all that you need. At the meeting of the council last January, the council decided, as you have probably read in the proceedings of the council, to recommend to the House of Delegates the revocation of the charter of one of the county medical societies in the state. That matter of dispute in that county society has been satisfactorily settled, so that the council will withdraw that recommendation, and the charter of that county society will continue as it has in the past.

Dr. A. J. Patek, Milwaukee: Mr. President, is this the time for presenting any new business, or have you a special program you want to finish first?

President: There is nothing else to report to the House of Delegates at present, and if there is any miscellaneous or new business, now is the time to present it.

Dr. A. J. Patek, Milwaukee: It occurs to me, now that Dr. Hayes is nominated, and his election to be presumed, that this will leave a vacancy among the councilorships? Dr. Hayes is Councilor of the 12th District. My recollection is that two years ago Dr. Dearholt was Councilor, and when he became President, was replaced by Dr. Hayes. It would be a happy turn of affairs, to elect Dr. Dearholt Councilor, inasmuch as Dr. Hayes will assume the presidency of the Society. And if it is in order, I would, in anticipation of Dr. Hayes' election, move the nomination and election of Dr. Dearholt as Councilor for the 12th District.

Dr. W. F. Zierath, Sheboygan: I second the motion.

President: Gentlemen, you have heard the motion as seconded. Are there any remarks, or are you ready for the question? All in favor of the motion as presented, will signify by saying "aye"; opposed, "no."

Motion carried unanimously.

President: Dr. Dearholt is elected as councilor for the 12th District in place of Dr. Hayes, who has been elected president.

Dr. S. S. Hall, Ripon: Mr. President and Gentlemen: The Society has been in the habit, in the case of some of our representatives to other bodies, of paying at least their railroad expenses. We have delegates to the American Medical Association, have had for years, and no provision has been made for taking care of them in that way. These men attend the meetings of the House of Delegates, and give their entire time in this work of the session, the scientific portion of the session, and as a rule they are doing good work for us. I make a motion that the Society pay their railroad expenses, transportation.

Motion seconded.

PRESIDENT: You have heard the motion as seconded. Are there any remarks? If not, all in favor of the motion that the Society pay the traveling expenses of the delegates to the American Medical Association, will signify by saying "aye"; opposed, "no."

Motion unanimously carried.

SECRETARY: Mr. President, the question now comes up regarding the place of meeting for next year. I think it has been pretty generally agreed by the members of the State Society that Milwaukee is the logical place to hold the meetings from now on. In fact, there is only one other town that can accommodate us in any sort of way as a meeting place; that is Madison, with the state capitol available; on the other hand, the Madison hotel accommodations are entirely inadequate for the attendance we usually have. However, the House of Delegates should this morning decide on the place of meeting for next year. That brings up the question of whether we will be able to hold the meeting next year. I do not think the members realize the difficulties under which this meeting is held. Dr. Lotz deserves the greatest amount of credit for the work he put in on the program. It is the most discouraging piece of work that I have seen done since I have been active in the Society. Man after man accepted invitations to come before the Society for papers, and then at the last moment wired that they had gone into the Service, and the Government had ordered them away; and it was impossible to get people from out of the state here. I find that a good many of the state societies this year have abandoned their meetings. I noticed the other day that Ohio, with a membership of 4500 have given up their meeting this year. So many are in the Service, and everyone else is engaged in war work on the local boards and advisory boards, and attending to the work of those who have left. If the war continues for another year and the present rate of induction of medical men into the Service continues, I predict that it will be impossible to hold a meeting next year, and impossible to get a program and attendance. Of course we all hope that before another year passes this war will be over, but we can not tell. I think it would be well if the House of Delegates this morning either authorize the council or some other body to decide later on, or early in the new year, whether it is advisable to try to hold a meeting next year, and if so, decide on the place where it should be held.

DR. JOSEPH SMITH, Wausau: Mr. Chairman, it occurred to me that possibly we might be able to hold a meeting that would be somewhat shorter than this meeting. Some of us who come here for the meetings of the House of Delegates, had to leave during the day on Tuesday. That means Tuesday, Wednesday and Thursday, and if we stay here for the program tomorrow, it means Friday also, that is four days. It seems to me that in view of the fact there is so much difficulty in getting material for the meeting, the time could be shortened, and our program be a limited one, perhaps, and the business necessary to be transacted could be transacted in that time. We could have a sharp, short, intensive meeting, and concentrate it in a shorter period of time, and still have something worth while. I think this matter deserves consideration.

DR. A. J. PATEK, Milwaukee: Mr. President, in line with these remarks, to suggest a possible means of getting together without spending too much time, the further thought occurs to me that it may be deemed essential by the council or by the officers, that a meeting be held in order to direct matters of executive character that may come up in the course of a year, and that ought not to be delayed, for fear of some complications. The Councilors might consider the advisability of merely calling a meeting of the House of Delegates for a one day session; and if they find it difficult to plan for a program, such might answer the purposes of the Society rather than have a meeting that is poorly attended, and with but a half-day program.

PRESIDENT: Gentlemen, if there is any change to be made in the program of holding meetings, so far as the change of time is concerned, the length of time that the meeting is to be held, whether one day, two days or three days, that can be left with the Council or Program Committee, but as far as postponing the meeting for another year is concerned, or not holding any meeting, that matter will have to be decided by the House of Delegates. The House of Delegates is the legislative body of the Society. However, the House of Delegates can refer to the council the action to be taken. It can refer to the council the advisory power whether a meeting is to be held, how long it is to be held, but you would have to decide now whether that can be done, or shall be done, or whether the program shall be carried on as in previous years.

DR. J. F. PEMBER, Janesville: I move that all matters pertaining to next year's meeting be left to the council.

PRESIDENT: To the January meeting of the council?

DR. PEMBER: Yes, sir.

Motion seconded.

PRESIDENT: Are there any remarks? If not, you have heard the motion. All in favor will signify by saying "aye"; opposed, "no."

Motion unanimously carried.

PRESIDENT: Gentlemen, the matter with relation to the next meeting of the State Medical Society of Wisconsin is left in the hands of the council, to be decided at the next meeting in January.

Are there any further matters to be brought up before the House of Delegates? If there is nothing else to come up, we are ready to receive the new president.

(The new President, Dr. D. J. Hayes, Milwaukee, was presented to the House of Delegates.)

PRESIDENT: Dr. Hayes, I am pleased to turn over the work of the Society to a better man than I am.

DR. D. J. HAYES, Milwaukee: All I can say, Gentlemen, is that I thank you from the bottom of my heart for the very great honor and confidence bestowed in electing me President of this Society, and I can assure you I will do all in my power to prove worthy of this confidence.

PRESIDENT: Is there any other business to come before the House? If not, a motion to adjourn until tomorrow morning at 8:30 will be in order.

DR. H. W. ABRAHAM, Appleton: Mr. President, I move that we adjourn until 8:30 tomorrow morning.

Motion seconded, put and carried.

HOUSE OF DELEGATES.

SESSION OCTOBER 4th, 1918, 8:30 A. M., AT THE AUDITORIUM, MILWAUKEE, WISCONSIN.

(Friday.)

Meeting called to order by the President.

PRESIDENT: Has the secretary anything to bring before the House of Delegates this morning?

SECRETARY: Nothing, Mr. President.

PRESIDENT: I do not know of any business to come before the House, so I suppose we might as well adjourn and call the council to order.

DR. S. S. HALL, Ripon: I move that we adjourn.

Motion seconded.

Motion put and carried.

REPORT OF THE ARRANGEMENT COMMITTEE.

Mr. President and Colleagues Assembled for the Seventy-Second Annual Session of The State Medical Society of Wisconsin:

Upon being asked to assume the chairmanship of the Arrangement Committee for this meeting, my first impulse was to refuse upon the theory that the work involved might prolong the condition which compelled me to withdraw from military service and which up to this time has prevented me from re-entering; but, upon consideration of the privilege afforded in being permitted to assist in the arrangements for a war time meeting and the contemplation of the personal satisfaction which would accrue from rendering even the slightest service toward the success of the administration of our Mentor, Constitutional Lawyer, Sachem, Nestor and All-around "Grand Old Man" of Wisconsin Medicine—our much beloved President, the position was accepted.

The problems involved in the arrangements for this meeting were, because of changed conditions with which you are all familiar, somewhat different from those incident to arranging for previous meetings. At the eleventh hour it became necessary to materially rearrange the plans with reference to the assembly rooms and exhibit space here at the Auditorium in order to avoid interfering with the questionnaire work of the Provost Marshal General's office, which is being done in the hall used for exhibit purposes last year. The final arrangements are not nearly as convenient as those which obtained during the last meeting, and which had been practically duplicated for this session, but the questionnaire work should, of course, take precedent over any other, and we know that the members and exhibitors will cheerfully adjust themselves accordingly.

The General Sessions will be held in the Plankinton Hall on the second floor instead of the Juneau Hall, as previously announced.

The Medical Section will meet in the general session quarters in the Plankinton Hall.

The Surgical Section will meet on the first floor immediately opposite the side entrance to the Exhibit Hall.

The Eye, Ear, Nose and Throat Section will meet in Committee Room "A" on the second floor.

Committee Rooms "C" and "D," opposite Plankinton Hall, are available for meetings of small committees.

The Councilors and House of Delegates may meet in the Auditorium Board of Directors' Room adjoining the Manager's Office on the second floor.

The Commercial Exhibits will be found in Juneau Hall on the first floor immediately to the left of the east entrance. The usual number of progressive and reliable firms are represented. In addition there will be in this hall "The Mayo Endowment Scientific Exhibit" and "The Milwaukee Health Department Exhibit." A systematic inspection of the twenty-six booths is quite as enlightening and as much in the interest of our patients as is attendance at the scientific discussions.

We have, due to obvious reasons, been somewhat less pretentious with respect to providing entertainment than were some of our predecessors. It was deemed advisable to omit entertainment arrangements for Wednesday evening in order to allow members to visit relatives, friends, hold college and class reunions, attend theatre parties, etc., without experiencing compunctions of conscience with respect to interfering with a prearranged program. The annual dinner, which we understand is and we believe quite properly so preferred to questionable cabaret exhibitions, is being arranged by Dr. D. E. W. Wenstrand and will be served in the Milwaukee Athletic Club Thursday evening at 7. Wives and families of physicians are invited and urged to attend. The toast program will be in keeping with the ideals of the Society and with the spirit of the times. Dr. W. E. Fairfield, of Green Bay, will act as toastmaster. We shall have as speakers Major J. D. McLean, M. C., U. S. Army. Past Assistant Surgeon Drew Luton, of the Great Lakes Training Station; Dr. W. A. Evans, of Chicago; Rev. C. H. Beale, of Milwaukee; and Hon. Herbert N. Laflin, of Milwaukee. Part of the program will consist of community singing lead by Mr. Arthur Daniels, of Milwaukee. Tickets for the dinner should be secured at the Registration Desk in the Exhibit Hall after registering and they must be secured at the same place not later

than Thursday noon in order to enable Dr. Wenstrand to make final arrangements at the Athletic Club.

The arrangements here at the Auditorium are in the immediate charge of Dr. M. L. Henderson with your humble servant as first lieutenant.

Your committee trusts that the arrangements will be entirely satisfactory and assures you that each member is yours to command throughout the entire session.

Respectfully submitted,

J. P. McMahon,
Chairman.

LIST OF MEMBERS OF THE STATE MEDICAL SOCIETY OF WISCONSIN, 1918

Abaly, W. C., Madison.
Abbott, LeRoy, Ontario.
Abelman, T. C. H., Watertown.
Abraham, H. W., Appleton.
Ackerman, Wm., Milwaukee.
Ackley, S. B., Oconomowoc.
Adams, G. F., Kenosha.
Adams, J. C., Superior.
Addleman, L. M., Wausau.
Ainsworth, H. H., Richland Center.
Albers, H. H., Allentou.
Alcorn, D. N., Steveus Poiut.
Alderson, J. C., Wausau.
Aldrich, L. I., Black Earth.
Aldridge, H. W., Manitowoc.
Alexander, Geo. L., Milwaukee.
Alexauder, Sara W., Hudsou.
Alexander, W. S., Oakfield.
Allen, C. F., Middleton.
Allen, Jessie P., Beloit.
Allen, L. P., Oshkosh.
Allen, Wm. J., Beloit.
Allison, Elizabeth, New York.
Altman, Maurice, Milwaukee.
Amundson, Karl K., Cambridge.
Amundson, Philip B., Mondovi.
Anderson, Carl M., Wild Rose.
Anderson, Harold B., Beloit.
Anderson, Jeus, Racine.
Andrae, R. W., Plainfield.
Andre, F. E., Kenosha.
Andrew, G. F., La Crosse.
Audrews, C. W., Waupaca.
Andrews, Malcom P., Beloit.
Andrews, Neil, Jr., Oshkosh.
Antoine, F. J., Prairie du Chien.
Aplin, F. W., Waukesha.
Armbruster, B. F., Milwaukee.
Armitage, John E., Milwaukee.
Armstrong, C. A., Prairie du Chien.
Armstroug, C. E., Oconto.
Armstrong, L. G., Boscobel.
Arnold, F. W., Milwaukee.
Arveson, Ray. G., Frederic.
Ashley, T. W., Kenosha.
Ashum, David W., Eau Claire.
Aubin, Jos. N., Peshtigo.
Aus, J. L. N., Deer Park.
Austria, W. F., Merrill.
Axley, A. A., Butternut.
Axtell, E. E., Marinette.
Axtell, Luella E., Marinette.
Aylward, Richard C., Madison.
Baasen, J. M., Mt. Calvary.
Babcock, Frank, Haugen.
Babcock, I. G., Cumberland.
Bach, J. A., Milwaukee.
Bachhuber, A. E., Mayville.
Bachhuber, L. M., Mayville.
Baer, A. N., Milwaukee.
Baer, C. A., Milwaukee.
Bailey, Mark A., Fennimore.
Bair, F. M., Lake Mills.
Baird, John, Superior.
Baird, J. C., Eau Claire.
Baker, G. R., Tomahawk.
Baker, J. H., Bryant.
Baker, J. C., Hawkins.
Baker, W. F., Birnamwood.
Baldwin, F. H., Bloomington.
Baldwin, G. E., Green Lake.
Balkwill, C. A., Grafton.
Bancroft, H. V., Blue Mound.
Banks, W. H., Hudson.
Bannen, W. E., La Crosse.
Barber, J. C., Marathon.
Bardeen, C. R., Madison.
Barnes, E. C., Ripon.
Barnes, H. T., Pewaukee.
Barnes, J. S., Milwaukee.
Barnette, J. R., Jr., Neenah.
Barnstein, Chas., Timothy.
Barnstein, J. E., Manitowoc.
Barrett, E. J., Sheboygan.
Barta, E. F., Milwaukee.
Barth, G. P., Milwaukee.
Bartran, W. H., Green Bay.
*Batchelet, C. W., Pine River.
Batcheller, Gertrude, Madison.
Batchelor, W. A., Milwaukee.
Bath, Dane H., Oshkosh.
Batty, A. J., Portage.
Bauch, Chas. W., Milwaukee.
Bauer, K. T., West Bend.
Baum, E. L., Milwaukee.
Baur, E. F., Milwaukee.
Bayer, W. H., Gleasou.
Baer, W. G., Mouroe.
Beckmann, C. R., La Crosse.
Beck, A. A., Coloma.
Becker, B. A., Silver Lake.
Becker, W. F., Milwaukee.
Bedford, Edgar, Sheboygan.
Bedley, H. E., Downing.
Beebe, C. M., Sparta.
Beebe, C. S., Milwaukee.
Beebe, L. W., Superior.
Beebe, P. A., Glenwood City.
Beebe, S. D., Sparta.
Beech, Geo. D., Adams.
Beeson, H. B., Cornell.
Beffel, J. M., Milwaukee.
Beier, A. L., Chippewa Falls.
Belitz, Alfred, Pepin.
Belitz, Wm., Cochrane.
Bell, A. R., Tomah.
Bellack, B. F., Columbus.
Bellin, Jos. J., Green Bay.
Bellin, Julius J., Green Bay.
Bellis, G. L., Milwaukee.
Belting, G. W., Orfordville.
Bender, Jesse, Ithica.
Bendixen, B. O., Kewaskum.
Bennett, Louis J., Ft. Atkinson.
Benson, G. H., Richland Center.
Bentley, J. E., Portage.
Berger, A. J., New Holstein.
Berglund, S. A., Marinette.
Beringer, L., Plymouth.
Bernhard, A., Milwaukee.
Bernstein, M. A., Kenosha.
Bertrand, J. H., De Forest.
Betz, J. C., Boscobel.
Beutler, W. F., Waupatosa.
Beyer, H., Pittsville.
Bickel, E. F., Oshkosh.
Bill, B. J., Genoa Junction.
Bilstad, G. E., Cambridge.
Binnewies, F. C., Janesville.
Binnie, Helen A., Poynette.
Bird, H. R., Madison.
Bird, M. D., Marinette.
Black, N. M., Milwaukee.
Blackburn, F. E., Cassville.
Blair, J. C., Hazel Green.
Blanton, Smiley, Randall's Island, N. Y.
Blewett, M. T., Markesan.
Blumenthal, R. W., Milwaukee.
Blumer, Edw., Monticello.
Bock, Otto B., Sheboygan.
Bodden, A. M., Milwaukee.
Boerner, R. W., Milwaukee.
Boger, T. A., Milwaukee.
Bolton, E. L., Chilton.
Booher, J. S., Richland Center.
Boorse, L., Milwaukee.
Borchardt, A. C., New London.
Borden, F. R., Plainfield.
Boren, J. W., Marinette.
Bornstein, Max, Milwaukee.
Bossard, C., Richfield.
Bossard, M., Spring Green.
Bowen, C. F., Richland Center.
Bowen, E. W., Watertown.
Bowen, H. P., Johnson Creek.
Boyce, S. R., Madison.
Boyd, C. D., Kaukauna.
Boyd, G. T., Fond du Lae.
Boyer, E. R., Rhinelauder.
Boynton, R. D., Grand Marsh.
Bradbury, E. L., Neillsville.
Bradfield, J. A. L., La Crosse.
Bradford, E. B., Hudson.
Brady, D. L., Cuba City.
Brah, A. J., Milwaukee.
Braun, Otto, Ashland.
Breckenridge, H. E., Racine.
Breeden, Roy F., Richland Center.
Brehm, H. J., Racine.
Brehm, Theodore, Racine.
Brey, P. F., Milwaukee.
Briggs, S. J., Madison.
Brockway, Frank, Oshkosh.
Broghammer, F. J., Superior.
Brook, J. J., Milwaukee.
Brooks, E. H., Appleton.
Brooks, L. M., Mendota.
Brown, A. D., Mineral Point.
Brown, Almon L., Wausau.
Brown, E. B., Beloit.
Brown, Frank E., Milwaukee.
Brown, G. Y. I., Milwaukee.
Brown, H. M., Milwaukee.
Brown, I. M., New London.
Brown, J. F., Kankakee, Ill.
Brown, R. C., Milwaukee.
Brueckbauer, H. G., Sheboygan.
Brumbaugh, E. V., Tulsa, Okla.
Brunckhorst, F. O., Kewauuee.
Bryant, J. R., Wausau.
Buchan, S. C., Racine.
Buchanan, R. C., Green Bay.
Buck, G. C., Platteville.
Buckley, T. J., Briggsville.
Buckley, W. F., Hartford.
Buckmaster, S. B., Janesville.
Buehler, J. W., Prairie du Sac.
Bugher, C. F., Ladysmith.
Bunting, C. H., Madison.
Burbach, T. H., Milwaukee.
Burdon, R. M., Green Bay.
Burger, H. E., Beloit.
Burgess, A. J., Milwaukee.
Burkhart, E. W., Menomonie Falls.
Burns, H. J., Hudson.
Burns, J. W., Soudan, Minn.
Burton, J. J., Milwaukee.
Busse, Alfred A., Jefferson.
Butler, E. F., Mosinee.
Butler, F. E., Menomonie.
Cady, M. P., Birnamwood.
Caffrey, A. J., Milwaukee.
Cahana, Stephen, Milwaukee.
Cahoon, Roger, Baraboo.
Cairns, Rolla, River Falls.
Caldwell, H. C., St. Croix Falls.
Caldwell, Margaret, Waukesha.
Calkins, H. J., Shawano.
Callahan, J. L., La Crosse.
Calvey, P. J., Fond du Lac.
Campbell, L. A., Clear Lake.
Campbell, W. B., Menomonie Falls.
Cantwell, W. H., Shawano.
Caples, B. M., Waukesha.
Cargill, N. W., Milwaukee.
Carhart, G. A., Milwaukee.
Carmichael, C. S., Helenville.
*Carroll, J. H., Milwaukee.
Carter, H. M., Madison.
Carter, R. M., Green Bay.
Carthans, A. H. C., Thiensville.
Cary, E. C., Reedsville.
Casey, Merle, Almond.
Cassels, G. S., Pt. Washington.
Cassidy, W. W., Durand.
Caswell, H. O., Ft. Atkinson.
Caughey, C. R., Kenosha.
Cavanaugh, T. E., Milwaukee.
Caveney, J. J., Milwaukee.

*Deceased.

Chandler, F. E., Waupaca.
Chandler, Jos., Pardeeville.
Chaney, Eug., Wauwatosa.
Chapman, F. M., Milwaukee.
Chapman, Veruon A., Milwaukee.
Charbouuean, A., Green Bay.
Charbonneau, E., Superior.
Charles, C. H., White Lake.
Chilson, Benj., Beloit.
Chlonpek, C. J., Green Bay.
Chorlog, J. K., Madison.
Christensen, C., La Crosse.
Christenseu, Emil, Two Rivers.
Christensen, F. C., Racine.
Christian, E. F., La Crosse.
Christiausen, Geo., Gaiesville.
Christofferson, A. L., Oshkosh.
Christoffersou, P. J., Wanpaca.
Churchill, B. P., Milwaukee.
Clark, Burton, Oshkosh.
Clark, F. T., Waupun.
Clark, M. H., Ripon.
Clark, R. B., Mouroe.
Clark, W. T., Ft. Atkinsou.
Clawsou, H. E., Red Grauite.
Cleary, B. L., Edgerton.
Cleary, J. H., Kenosha.
Clemeut, W. J., Berlin.
Coerper, E. E., Fredouia.
Coffey, C. J., Milwaukee.
Cohu, A. H., Milwaukee.
Coleman, H. M., Barrou.
Collins, D. B., Madison.
Collins, W. P., Racine.
Comhacker, H. E., Osceola.
Comhacker, L. C., Osceola.
Combs, C. J., Oshkosh.
Comee, William, Seymour.
Coukey, C. D., Duluth, Minn.
Coukliu, G. H., Superior.
Couley, J. M., Oshkosh.
Connell, D. R., Beloit.
Counell, F. G., Oshkosh.
Conroy, J. M., Nopeming, Minn.
Conway, H. P., Spring Valley.
Cook, C. S., Evansville.
Cook, E. H., Watertown.
Cook, F. S., Ean Claire.
Cooksey, R. T., Madison.
Coon, G. E., Milton Jct.
Coou, J. W., Steveus Point.
Cooney, Ed., Appleton.
Cooper, C. A., Norwalk.
Cooper, E. S., Almond.
Copelaud, Ernst, Milwaukee.
Corbett, J. F., Alhambra, Cal.
Corbett, M. E., Oshkosh.
Coruwall, W. B., Turtle Lake.
Corr, Anna B., Juneau.
Corr, J. T., Racine.
Cottingham, M. D., Lake Geneva.
Conch, E. E., West Allis.
Cowan, W. F., Stevens Point.
Cowles, R. L., Green Bay.
Creasy, L. E., South Wayne.
Cremer, C. H., Cashton.
Cristman, E. S., Almeua.
Crocket, W. W., Beloit.
Crommett, H. B., Amery.
Cron, C. O., Camp Douglas.
Crone, V. D., Peoria, Ill.
Crosby, E. P., Arnott.
Crosby, Geo. W., Sheboygan.
Crowe, N. F., Walworth.
Cummings, J. H., Superior.
Cunningham, J. N., Stanley.
Cunniugham, R. B., Cadott.
Cunningham, Wilson, Platteville.
Curless, G. W., Walworth.
Currens, J. R., Two Rivers.
Currer, P. M., Milwaukee.
Curtin, A. L., Milwaukee.
Curtin, J. J., Sawyer.
Cutler, J. S., Wauwatosa.
Cutter, J. D., Tomahawk.
Dailey, P. J., Milwaukee.
Dake, A. J., Viola.
Dana, A. C., Fond du Lac.
Danforth, Q. H., Omro.
Daniels, L. J., Milwaukee.
Daniels, W. N., Mosinee.
Darby, G. S., Brodhead.
Darling, Earl, Milwaukee.
Darling, F. E., Milwaukee.
Darling, Walt. G., Milwaukee.
Darling, W. S., Milwaukee.
Davelaar, G. W., Milwaukee.
Davies, R. E., Wankesha.
Davin, C. C., Weyerhauser.
Davis, F. A., Madison.
Dawley, G. T., New London.
Dawsou, C. A., River Falls.
Dawson, D. L., Rice Lake.
Dean, J. P., Madison.
Dean, Jos. P., Madison.
Dearholt, H. E., Milwaukee.
De Besch, J. A., Milwaukee.
*DeBoth, E. R., Green Bay.
Decker, H. J., Milwaukee.
DeCock, J. L., Angelica.
Deicher, H. F., Plymouth.
Delaney, H. O., Beloit.
Delap, R. H., Richland Center.
DeNeven, A. C., Wyocena.
Denham, J. F., Boyceville.
Dennis, Jas. F., Waterloo.
Derge, H. F., Eau Claire.
Dernehl, P. H., Milwaukee.
De Swarte, L. T., Milwaukee.
Devine, C. B., Marshall.
DeVoe, C. A., Berliu.
Dewey, R. F., Wauwatosa.
DeWire, M. V., Sharon.
Dickenson, G. H., Milwaukee.
Differt, C. C., Milwaukee.
Dill, G. M., Prescott.
Dodd, J. M., Ashland.
Doege, K. W., Marshfield.
Doern, W. G., Milwaukee.
Doerr, Aug., Milwaukee.
Dohearty, F. P., Appleton.
Dohearty, W. H., Peshtigo.
Domann, W. G., New Butler.
Donaldsou, G. F., Shiocton.
Donnell, J. E., Cuba City.
Donuelly, F. J., Monches.
Douohue, E. J., Antigo.
Donohue, M. J., Antigo.
Donohue, W. E., Manitowoc.
Donovan, J., Milwaukee.
Donovan, J. P., Madison.
Doolittle, J. C., Lancaster.
Doolittle, S. W., Lancaster.
Dorr, A. M., Milwaukee.
Dougherty, C. F., Richland Center.
Doughty, P. H., Burnett.
Douglas, F. A., La Crosse.
Doyle, J. H., Little Chute.
Doyle, John N., Neshkora.
Drake, F. I., Mendota.
Draper, M. H., Deerfield.
Drew, R. J., Alma Center.
Drexel, A., Milwaukee.
Dreyer, R. A., Wheeler.
Dries, Jos., Milwaukee.
Driessel, H., Barton.
Driessel, S. J., Barton.
Drissen, W. H., Pt. Washington.
Drozniakiewicz, L. J., Milwaukee.
*Dube, F. de S., Centuria.
Duclos, A. A., Kilbourn.
Du Frenne, M. F., Middleton.
Dunn, E. A. A., Platteville.
Durner, U. J., Milwaukee.
Durr, W. E., Milwaukee.
Dusenbury, G. E., Amherst.
Dwight, C. G., Madison.
Eames, H. F., Egg Harbor.
Eastman, J. R., Kenosha.
Echols, C. M., Milwaukee.
Eck, G. E., Lake Mills.
Edwards, A. C., Arcadia.
Edwards, W. A., La Crosse.
Egan, G. J., La Crosse.
Egland, G. R., Sturgeon Bay.
Egloff, L. W., Pewaukee.
Ehmer, J. W., Lomira.
Eickelberg, F. A., Reesville.
Eidam, L. W., La Crosse.
Ekblad, V. E., Superior.
Elfers, J. C., Sheboygan.
Ellenson, E. P., Chippewa Falls.
Elliott, E. S., Fox Lake.
Elliott, J. T., Rhinelander.
Elliott, R. S., Laona.
Ellis, W. E., White Lake.
Ellis, W. H., Barron.
Elmergreen, R., Milwaukee.
Elsom, J. C., Madison.
Elvis, F. B., Medford.
Engsberg, W. A., Lake Mills.
Ennis, S. A. J., Shullsburg.
Epley, O. H., New Richmond.
Erdman, C. H., Stanley.
Erickson, H. C., Stanley.
Ernst, G. R., Milwaukee.
Evans, C. A., Milwaukee.
Evans, E., La Crosse.
Evans, E. P., South Milwaukee.
Evaus, J. S., Madison.
*Evaus, N. C., Mt. Horeb.
Evans, Owen, Bangor.
Evert, F. T., Retreat.
Faber, C. A., Milwaukee.
Fairfield, W. E., Green Bay.
Falk, V. S., Stoughtou.
Farnham, C. R., Milwaukee.
Farnsworth, A. L., Barahoo.
Farnsworth, F. B., Janesville.
Farr, J. F., Eau Claire.
Farrell, A. M., Two Rivers.
Faulds, R. C., Ahrams.
Fazen, L. E., Racine.
Fechter, F. J., Elkhart Lake.
Federman, E. H., Montello.
Federspiel, M. M., Milwaukee.
Fellman, G. H., Milwaukee.
Felter, Edw., Plymouth.
Fenelon, C. D., Phillips.
Festerling, E. G., Reedsville.
Fickes, H. C., Owen.
Fidler, C. A., Milwaukee.
Fiebiger, G. J., Waterloo.
Fiedler, O. A., Sheboygan.
Field, F. T., Elroy.
Fifield, G. W., Janesville.
Finuey, W. H., Clintouville.
Fitzgerald, J. J., Eagle.
Fitzgerald, R. E., Milwaukee.
Fitzgibbon, W., Milwaukee.
Fitzpatrick, M. L., Milwaukee.
Flanagan, G. J., Kaukauna.
Flatley, M. A., Antigo.
Fleek, J. L., Brodhead.
Fleming, E. E., Wausau.
Fletcher, E. A., Milwaukee.
Fletcher, F. E., Ashland.
Fletcher, Wm., Salem.
Fleury, F. D., Omro.
Flynn, L. H., Eau Claire.
Flynn, R. E., La Crosse.
Foat, J. S., Ripon.
Foerster, O. H., Milwaukee.
Foley, F. P., Dorchester.
Foley, L. J., Milwaukee.
Folsom, W. H., Fond du Lac.
Force, O. O., Pardeeville.
Ford, W. B., Milwaukee.
Forkin, G. E., Menasha.
Fortier, C. A. H., Milwaukee.
Fortner, W. H., Princeton.
Fosse, B. O., Beloit.
Foster, A. M., Kaukauna.
Foster, A. M., Racinc.
Foster, J. H. A., Cornell.
Fowle, F. F., Wauwatosa.
Fowle, L. H., Milwaukee.
Fowler, J. H., Lancaster.
Fowzer, L. R., Manawa.
Fox, G. W., Milwaukee.
Fox, Paul A., Beloit.
Fox, Phillip, Madison.
Fox, Phil. A., Milwaukee.
Fox, P. R., Madison.
France, J. J., Milwaukee.
Frauces, J. H., Bloomer.
Francois, S. J., New Glarus.
Frank, J. H., Neillsville.
Frank, John H., Milwaukee.
Franklin, I., Sheboygan.
Franzel, J. E., Ft. Atkinson.
Frawley, R. M., Wausau.
Freudenberg, J. A., Markesan.
Frew, J. W., Milwaukee.
Frey, F. H., Wausau.
Frey, P. G., Washburn.
Frick, Lewis, Two Rivers.
Friedrich, R. O., Milwaukee.
Friend, L. J., Merrill.
Froggatt, W. E. L., Cross Plalus.
*Frost, Carrie, Almond.
Fucik, E. J., Williams Bay.
Fuldner, Louis, Milwaukee.
Fuller, C. O., Stratford.
Fulton, H. A., Eau Claire.
Fulton, W. A., Burlington.
Furstman, J. M., La Crosse.
Gaenslen, F. J., Milwaukee.
Gallogly, M. J., Milwaukee.
Galloway, A. D., Clayton.
Ganser, W. J., Madison.
Gates, A. J., Tigerton.
Gates, Eugene, Two Rivers.
Gault, J. A., Lancaster.

*Deceased.

Gaunt, P. F., Oconto.
Gendron, A. E., River Falls.
Genter, A. E., Sheboygan.
Gephart, C. H., Kenosha.
Gerend, A., Cato.
Germano, G., Kenosha.
Giesen, C. W., Superior.
Gifford, H. B., Juda.
Gilbert, H. A., Madison.
Gilchrist, R. T., Milwaukee.
Gilles, A. S., Waukesha.
Gillespie, W. W., Milwaukee.
Gillette, H. E., Packwaukee.
Glasier, M. B., Bloomington.
Gleason, C. M., Oconomowoc.
Gnagi, W. B., Monroe.
Gobar, G. G., Muscoda.
Goddard, J. B., Eau Claire.
Godfrey, Jos., Lancaster.
Godfrey, Rush, Lancaster.
Goerkermann, W. H., Rochester, Minn.
Goetsch, O. F., Hustisford.
Goggius, G. F., Wrightstown.
Goggins, J. W., Malone.
Goggins, R. J., Oconto Falls.
Golley, F. B., Milwaukee.
Goodfellow, J. R., Superior.
Gordon, J. B., Shawano.
Gordon, J. S., Milwaukee.
Gorst, Chas., Daytona, Florida.
Gosin, D. F., Green Bay.
Gramling, H. J., Milwaukee.
Gramling, J. J., Dousman.
Graner, L. H., Coleman.
Grannis, I. V., Menomonie.
Gratiot, C. C., Shullsburg.
Gratiot, Wm. M., Mineral Point.
Graves, L. S., Wilton.
Gray, A. W., Milwaukee.
Gray, R. H., La Crosse.
Greeley, H. P., Madison.
Green, M. K., Mendota.
Green, W. A., Wausau.
Greenberg, H., Milwaukee.
Greenwood, S. D., Neenah.
Gregory, A. T., Elroy.
Gregory, D. H., De Pere.
Gregory, Frank, Valders.
Gregory, W. W., Stevens Point.
Grinde, G. A., Cumberland.
Grissom, C. B., La Crosse.
Griswold, C. M., Alma Center.
Griswold, F. C., Mazomanie.
Grob, A. R. P., Milwaukee.
Grosskopf, E. C., Milwaukee.
Grotjan, Wm. F., Milwaukee.
Ground, W. E., Superior.
Grove, W. E., Milwaukee.
Groves, R. J., Lodi.
Gunderson, A., La Crosse.
Gunderson, C. A. S., Madison.
Gunther, Emil, Sheboygan.
Gunther, Otto, Sheboygan.
Gunther, T. J., Sheboygan.
Gunther, Wm. H., Sheboygan.
Gutsch, O. J., Sheboygan.
Guttman, Paul, Kellnersville.
Guy, J. E., Milwaukee.
Gygi, John, Big Falls.
Habhegger, C. J., Watertown.
Hackett, J. H., Milwaukee.
Hadley, D. A., Oconomowoc.
Hageman, F. H., Milwaukee.
Haight, A. L., Crystal Falls, Mich.
Hake, Cecil B., Milwaukee.
Hall, C. H., Madison.
Hall, S. S., Ripon.
Halsey, R. C., Lake Geneva.
Hambley, T. J., Hurley.
Hamilton, D. B., Dodgeville.
Hammond, F. W., Manitowoc.
Hanko, Mary E., Plain.
Hankwitz, P. G., Milwaukee.
Hanley, W. J., Kenosha.
Hannum, H. H., Bayfield.
Hansen, John, Glenbeulah.
Hanson, J. W., Milwaukee.
Hanson, W. C., Racine.
Harbert, Helen, Kenosha.
Hardgrove, J. H., Eden.
Hardy, C. F., Milwaukee.
Hargarten, L. J., Milwaukee.
Harkins, J. P., Forest Junction.
Harlow, G. A., Milwaukee.
Harper, C. A., Madison.
Harrington, T. L., Milwaukee.
Harris, F. M., Fond du Lac.
Harter, A. F., Marathon.
Harvey, J. R., Footville.
Haskell, M. W., Richland Center.
Hastings, J. F., Kenosha.
Hatch, W. E., Superior.
Haubrick, H. J., Oshkosh.
Hausberry, J. S., Wonewoc.
Hausberry, P. H., Hillshoro.
Haushalter, H. P., Milwaukee.
Hansmann, N. E., Kewaskum.
Haven, W. S., Racine.
Hayden, A., Shullsburg.
Hayes, C. A., Chippewa Falls.
Hayes, D. J., Milwaukee.
Hayes, E. P., Eau Claire.
Hayes, E. S., Eau Claire.
Hayman, C. S., Boscobel.
Hayman, L. H., Pasadena, Cal.
Hayward, J. C., Marshfield.
Hebron, R. A., Cataract.
Hecker, Wm., Beloit.
Hedges, A. N., Butternut.
Heeb, H. J., Milwaukee.
Heffron, J. J., Milwaukee.
Hefty, C. A., New Glarus.
Hegner, G. T., Appleton.
Heiden, H., Sheboygan.
Heidner, A. H., West Bend.
Heim, R. R., Marinette.
Heising, A. F., Menomonie.
Helgeson, E. J., Evansville.
Helland, J. W., Spring Grove, Minn.
Helm, Arthur C., Beloit.
Helm, Ernest C., Beloit.
Helm, Harold M., Beloit.
Helz, J. W., Fond du Lac.
Henderson, M. L., Milwaukee.
Hendrickson, H., Green Bay.
Henika, G. W., Madison.
Henney, C. W., Portage.
Hennig, E. L., Beloit.
Heraty, J. A., Milwaukee.
Heraty, J. E., Bloomington.
Hering, E. R., Shell Lake.
Herrick, E. L., Kenosha.
Herron, A. L., Milwaukee.
Hertzman, C. O., Ashland.
Hervey, J. A., Milwaukee.
Hess, C. F., Madison.
Hess, J. W., Adell.
Hicks, L. W., Burlington.
Hidershide, G. N., Arcadia.
Higgins, E. G., Melrose.
Higgins, S. G., Milwaukee.
Hilger, W. F., Milwaukee.
Hill, W. B., Milwaukee.
Hilliard, H. G., Minong.
Hilton, G. F., Sturgeon Bay.
Hinckley, H. G., Merrill.
Hines, L. L., Rockbridge.
Hinrichs, R. G., Ashland.
Hinu, L. P., Fond du Lac.
Hinrichsen, J. A., Larsen.
Hipke, G. A., Milwaukee.
Hipke, Wm., Marshfield.
Hirschboeck, J. G., Forestville.
Hitz, H. B., Milwaukee.
Hodges, F. L., Monroe.
Hodgson, A. J., Waukesha.
Hoermann, R. B., Milwaukee.
Hoffman, E. F., Lone Rock.
Hoffman, J. G., Hartford.
Hoffman, P. A., Campbellsport.
Hoffmier, L. A., Superior.
Hogan, J. H., Racine.
Hogan, J. M., Oshkosh.
Hogue, G. I., Milwaukee.
Holbrook, A. T., Milwaukee.
Hollenbeck, N. W., Milwaukee.
Holliday, Marion E., Oshkosh.
Holm, J. H., Kenosha.
Holmes, B. H., Delavan.
Holt, W. L., Beloit.
Holtz, H. M., Beaver Dam.
Holz, A. P., Seymour.
Hopkins, Minnie, Oconto.
Hopkinson, D., Milwaukee.
Horne, G. C., Black River Falls.
Horsewell, U. M., Wausaukee.
Hosmer, M. S., Ashland.
Houck, Mary P., La Crosse.
Hougen, Ed., Grand Rapids.
Hough, A. G., Madison.
Housley, H. W., Granton.
Hovde, A. G., Superior.
Howell, E. C., Fennimore.
Howison, N. L., Menomonie.
Hoyer, A. A., Randolph.
Hoyer, G. C., Milwaukee.
Hoyt, G. E., Menomonee Falls.
Huhenthal, J. C., Belmont.
Huenuekens, Jos. H., Milwaukee.
Huff, F. C., Sturgeon Bay.
Hughes, J. R., Dodgeville.
Hull, E. S., Milton Jct.
Hummel, W. J., Ahlemans.
Hunt, E. A., Oshkosh.
Hunt, E. M., Goodman.
Hunt, F. O., Fall River.
Hurd, H. H., Chippewa Falls.
Hurth, O. J., Cedarburg.
Irvine, W., Manawa.
Irwin, G. H., Lodi.
Irwin, H. J., Baraboo.
Ishmael, O. E., Mt. Horeb.
Ison, G. W., Crandon.
Iversou, M., Stoughton.
Ivy, R. H., Milwaukee.
Jackey, F. D., Thorp.
Jackson, Edw., Milwaukee.
Jackson, F. A., Eldorado.
Jackson, J. A., Jr., Madison.
Jackson, J. A., Sr., Madison.
Jackson, J. A., Mosinee.
Jackson, R. H., Madison.
Jacobs, E. C., Durand.
Jacobs, S. A., Milwaukee.
James, A. W., Muscoda.
Jamieson, Geo., Lone Rock.
Jardine, E. W., Alma.
Jefferson, H. A., Clintonville.
Jeffery, L. A., Hebron, Nebraska.
Jegi, H. A., Galesville.
Jensen, A. B., Menasha.
Jermain, H. F., Milwaukee.
Jermain, L. F., Milwaukee.
Jewell, T. M., Mindoro.
Jobse, P. H., Milwaukee.
Johse, W. P., Milwaukee.
Johnson, A. T., Sauk City.
Johnson, A. W., Milwaukee.
Johnson, C. E., Seattle, Washington.
Johnson, Fred, Eau Claire.
Johnson, F. G., Iron River.
Johnson, F. P., Ontario.
Johnson, H. B., Tomah.
Johnson, H. C., Bruce.
Johnson, J. C., Ogdensburg.
Johnson, L. M., Chicago, Ill.
Johnston, G. B., Abbottsford.
Johnston, H. E., Oshkosh.
Johnston, W. M., Dale.
Johnston, W. W., Racine.
Jones, A. W., Randolph.
Jones, David T., Wausau.
Jones, E. H., Weyauwega.
Jones, M. L., Wausau.
Jones, R. W., Wausau.
Jones, Susan, Racine.
Jones, Walter C., Fairfield, Ala.
Jorgensen, P. P. M., Kenosha.
Joseph, W. A., Hancock.
Judge, T. A., Milwaukee.
Juergens, L. W., Milwaukee.
Junck, J. A., Sheboygan.
Kagy, M. O., Milwaukee.
Kahn, Jos., Milwaukee.
Kalling, H., Black River Falls.
Kappelmann, F. W., Milwaukee.
Karnopp, G. L., Mishicott.
Karsten, A. C., Horicon.
Kastner, A. L., Milwaukee.
Katz, H. M., Cedarburg.
Kaumheimer, G. J., Milwaukee.
Kay, H. M., Madison.
Kaysen, Ralph, Watertown.
Keech, J. S., Racine.
Keenan, Harry, Stoughton.
Keithley, J. A., Palmyra.
Keithley, John W., Beloit.
Keland, G. A., Madison.
Keland, H. B., North Cape.
Keller, J. M., St. Louis, Mo.
Kellner, V. V., Maribel.
Kellog, E. W., Milwaukee.
Kelly, C. D., Blair.
Kelly, D. M., Baraboo.
Kelly, F. H., Merrill.
Kelly, John, Cato.
Kelly, W. W., Green Bay.
Kemper, W. G., Manitowoc.
Kennedy, W. R., Milwaukee.
Kenney, G. F., Milwaukee.
Kenney, R. D., Milwaukee.
Kermott, E. P., Hudson.
Kersten, A. M., De Pere.
Kersten, N. M., De Pere.

*Deceased.

Kettelhut, E. J., Milwaukee.
Ketterer, E. A., Moutfort.
Keyes, T. B., Chicago, Ill.
Kiefer, J. G., Milwaukee.
King, C. F., Hudson.
King, G. F., Green Bay.
King, H. V., Pepin.
Kings, J. S., Watertown.
Kinne, Edw., Elkhorn.
Kissinger, C. A., Melrose.
Kissling, A. C., Milwaukee.
Kitzke, F. W., Milwaukee.
Klein, J. T., Milwaukee.
Kleinhoehl, J. W., Random Lake.
Kleinhans, F. A., Milwaukee.
Kleinhans, M. A., Milwaukee.
Kleinschmidt, H. W., Oshkosh.
Klemm, L. F., Milwaukee.
Knapp, E. J., Rice Lake.
Knauf, A. J., Sheboygan.
Knauf, F. P., Kiel.
Knauf, G. E., Sheboygan.
Knauf, N. J., Chilton.
Knowles, W. L. M., Spooner.
Knox, C. S., Superior.
Knox, E. S., Bowler.
Knutson, Oscar, Osseo.
Koch, M. J., Milwaukee.
Koehler, A. G., Oshkosh.
Koehler, J. P., Milwaukee.
Korthals, F. J., Milwaukee.
Kradwell, W. T., Wauwatosa.
Krahn, A. J., Beaver Dam.
Kratsch, A. W., Milwaukee.
Kraut, Elgie, Beetown.
*Krebs, Wm. D., Green Bay.
Kreitzer, A. J., Sawyer.
Kremers, Alex, Milwaukee.
Krentzer, A. G., Milwaukee.
Kriz, G. H., Milwaukee.
Krohn, H. C., New Holstein.
Krueger, B., Cudahy.
Krumme, S. A., Fond du Lac.
Krygiar, A. A., Milwaukee.
Kulig, A. H., Independence.
Kunuy, Bartholomew, Cylon.
Kyes, S. M., Owen.
Kyllo, J. C., Superior.
LaBreck, F. A., Eau Claire.
Lacey, S. W., Footville.
Lademann, O. E., Milwaukee.
Ladwig, W. A., Wausau.
Laird, J. J., Black Creek.
Lalor, J. C., Sauk City.
Lambeck, F. J., Milwaukee.
Lampson, H. G., Washburn.
Lang, Jacob, Milwaukee.
Langenfeld, P. F., Theresa.
Langland, P., Milwaukee.
Lansdowne, F. B., Kenosha.
Larsen, G. A., Hayward.
Lasche, P. G., Richland Center.
Latham, C. O., Green Bay.
Laughlin, D. M., Milwaukee.
Laughlin, T. J., Milwaukee.
Law, W. G., Glidden.
Lawhorn, C. C., Milwaukee.
Lawler, C. F., Hilbert.
Lawler, G. W., Sussex.
Lawler, T. S., Lyndon Station.
Lawrence, G. H., Fond du Lac.
Layton, O. M., Fond du Lac.
LeCron, W. L., Milwaukee.
Lee, J. H., Iola.
Lee, M. A., Superior.
Leeson, F. W., Beloit.
Legnard, J. B., Houston, Texas.
Lehmann, F. W., Hartford.
Lehnkering, C. F., Darlington.
Leicht, Philip, Lake Mills.
Leitzell, P. W., Benton.
Leland, A. M., Whitewater.
Lemmel, J. T., Albany.
Lemmer, G. M., Spooner.
Lemon, C. H., Milwaukee.
Leonnard, C. W., Fond du Lac.
Lester, W. A., Onalaska.
Lettenberger, Jos., Milwaukee.
Levitas, I. E., Green Bay.
Lewis, C. H., Milwaukee.
Lewis, J. M., Bloomington.
Lid, T. A., Marinette.
Lillie, O. R., Milwaukee.
Lincoln, W. S., Dodgeville.
Lindores, J. D., Stevens Point.
Lindow, G. E., Watertown.
Lindsay, W. T., South Madison.
Linkman, E. J., Milwaukee.

Linn, W. N., Oshkosh.
Lintleman, F. R., Janesville.
Lippitt, S. H., Milwaukee.
Lobedan, E. T., Milwaukee.
Lochemes, W. T., Milwaukee.
Lockhart, C. W., Melleu.
Lockhart, J. W., Oshkosh.
Loeveuhart, A. S., Washington, D. C.
Loge, E. S., Milwaukee.
Lohmiller, R. K., Superior.
Longley, J. R., Fond du Lac.
Loomis, E. E., Janesville.
Loope, T. E., Iola.
Looze, J. J., Grand Rapids.
Lorenz, W. F., Menomonie.
Lothrop, C. A., Ripon.
Lotz, Oscar, Milwaukee.
Loughnan, A. J., Ocoonomowoc.
Love, G. E., Waukesha.
Ludden, H. D., Mineral Point.
Lueck, G. W., La Crosse.
Luhman, F. S., Manitowoc.
Lumley, W. A., Ellsworth.
Lumsden, Wm., Knapp.
Lundmark, L. M., Ladysmith.
Lyman, J. V. R., Eau Claire.
Lynch, D. W., West Bend.
Lynch, H. M., Allenton.
Lyons, J. A., Eau Claire.
Lyons, M. W., Wayzata, Minn.
McBeath, H. F., Milwaukee.
McBeath, N. E., Livingston.
McCabe, H., Milwaukee.
McCabe, P. G., Fond du Lac.
McCallin, A. E., Waupaca.
McCallister, G. H., Avoca.
McCann, Edith, Milwaukee.
McCarey, A. J., Green Bay.
McCarthy, H. C., Richland Center.
McCarty, E. O., Knapp.
McChesney, W. M., Edgerton.
McClure, G. H., Westboro.
McComb, I. N., Brillion.
McCorkle, S. C., Milwaukee.
McCormick, H., New Auburn.
McCormick, W. C., Tomahawk.
McCracken, J. O., Kenosha.
McCracken, R. W., Union Grove.
McCrory, J. T., Racine.
McCutcheon, W. R., Thorp.
McDermott, L. C., Gratiot.
McDill, J. R., Milwaukee.
McDonald, H. F., Hollendale.
McDougall, G. T., Fond du Lac.
McDowell, A. J., Soldiers Grove.
McEachern, W. A., Superior.
McGarty, M. A., La Crosse.
McGauley, F. M., Fond du Lac.
McGill, P. J., Superior.
McGovern, J. J., Milwaukee.
McGovern, P. H., Milwaukee.
McGrath, Earle F., Appleton.
McGrath, Edw., Baraboo.
McGuire, W. H., Janesville.
McHugh, F. T., Chippewa Falls.
McIndoe, T. B., Rhinelander.
McKee, F. W., Richland Center.
McKellar, A., Blanchardville.
McKeon, P., New Richmond.
McKinnon, G. E., Prentice.
McKivett, W., Milwaukee.
McKnight, G. B., Fond du Lac.
McLaughlin, H. J., Bloomington.
McMahon, F. B., Milwaukee.
McMahon, J. P., Milwaukee.
McNaughton, W. T., Milwaukee.
McNicholas, L. T., Athens.
McRae, J. D., Chippewa Falls.
McRae, M. F., Milwaukee.
Maas, W. C., Rio.
MacArthur, D. S., La Crosse.
MacCollum, C. L. R., Manitowoc.
MacCormack, E. A., Whitehall.
MacCormack, R. L., Alma Center.
MacDonald, Edw., Cuba City.
MacDonald, W. H., Lake Geneva.
Mack, J. A., Madison.
MacKechnie, R. S., Hillsboro.
Mackoy, F. W., Jorden, Minn.
MacLachlan, W. G., McFarland.
MacLaren, J. B., Appleton.
MacMillan, A. E., Stevens Point.
Madison, J. D., Milwaukee.
Maechtle, F. W., West Allis.
Maes, C. G., Kimberly.
Malkin, G. M., Milwaukee.
Malloy, F. E., Random Lake.
Malone, F. A., Waterford.

Malone, T. C., Milwaukee.
Malone, W. F., Milwaukee.
Marchessault, J. A., Ashland.
Markson, S. M., Milwaukee.
Maroney, F. W., La Crosse.
Marquis, A. J., Wausaukee.
Marrs, F. A., Stevens Point.
Marsden, T. H., Fennimore.
Marsh, J. M., Elkhorn.
Marshall, F. P., North Fond du Lac.
Marshall, V. F., Appleton.
Martens, W. A., Milwaukee.
Mason, C. H., Superior.
Mason, E. L., Eau Claire.
Mason, G. F., Milwaukee.
Mason, V. A., Marshfield.
Mathiesen, J., Eau Claire.
Mathesou, A., Neillsville.
Matthews, J. B., Milwaukee.
Mauermann, J. F., Monroe.
Maurer, A. A., La Crosse.
Maxan, M., Schleisingerville.
Maxson, F. S., Milwaukee.
May, J. V., Marinette.
Meachem, J. G., Jr., Racine.
Meachem, J. G., Sr., Racine.
Meacher, B. C., Portage.
Meade, F. S., Madison.
Meany, J. E., Manitowoc.
Mears, G. V., Fond du Lac.
Mecum, J. B., Bagley.
Mehigan, D. D., Milwaukee.
Meiklejohn, D. V., Fond du Lac.
Melaas, W. G., Beloit.
Melster, W. H., Milwaukee.
Mensing, E., Milwaukee.
Merrill, W. G., Grand Rapids.
Merten, P. J., Milwaukee.
Mertens, H. G., Bayfield.
Mesch, A. A., Saukville.
Messmer, Clemens, Milwaukee.
Meusel, Harry, Oshkosh.
Meyer, E. E., Brillion.
Meyer, H. C., La Crosse.
Meyers, J. M., Superior.
Meyst, C. H., Burlington.
Middleton, W. S., Madison.
Midelfart, H. C., Eau Claire.
Midgley, A. E., Whitewater.
Mieding, A. E., Milwaukee.
Milbee, H. H., Marshfield.
Millard, F. D., Milwaukee.
Miller, E. A., Clintonville.
Miller, E. W., Milwaukee.
Miller, H. C., Whitewater.
Miller, Thos., Ocoonomowoc.
Miller, W. J., La Valle.
Miller, W. S., Madison.
*Mills, N. K., Odanah.
Mills, N. P., Appleton.
Minahan, J. R., Green Bay.
Minahan, R. E., Green Bay.
Minahan, P. R., Fond du Lac.
Mishoff, I. D., Milwaukee.
Mitchell, E. J., Brodhead.
Mitchell, F. W., Ogema.
Mitchell, R. E., Eau Claire.
Mitchell, S. R., Milwaukee.
Mitten, A. A., Milwaukee.
Mix, H. C., Green Bay.
Mock, F. C., Milwaukee.
Moe, H. B., Blanchardville.
Moeller, J., Milwaukee.
Moffat, H. L., Arpin.
Mollinger, S. M., Milwaukee.
Monk, R. W., Neillsville.
Monroe, W. B., Monroe.
Monstad, J. W., New London.
Montgomery, A., Milwaukee.
Montgomery, R. C., Madison.
Montgomery, Wm., Eau Claire.
Moore, E. E., Martins Ferry, Ohio.
Moore, G. W., Antigo.
Moore, L. A., Monroe.
Moore, W. N., Appleton.
*Moquin, E. I., Fairwater.
Moraux, Felix, Luxemburg.
Morgan, J. J., Durand.
Morgenroth, H. W., Oshkosh.
Mork, Ole, Blair.
Morley, F. E., Viroqua.
Morris, E. K., Merrill.
Morris, R. C., Ft. Atkinson.
Morris, S. J., Madison.
Morrison, M., Cashton.
Morrison, W. W., Edgerton.
Morse, E. A., Appleton.
Mortenson, O. N., Grand Rapids.

*Deceased.

Morter, C. W., Milwaukee.
Morter, R. E., Milwaukee.
Morton, H. H., Cobb.
Monntin, J. M., Milwaukee.
Moyer, S. R., Monroe.
Mudroch, J. A., Columbus.
Mueller, W. E., Green Bay.
Muenzner, R. J., Milwaukee.
Mulford, E. R., La Crosse.
Mulvaney, F. M., Marion.
Munger, D. C., Ellsworth.
Munkwitz, F. H., Milwaukee.
Mnnn, W. A., Janesville.
Mnrphy, E. C., Wilmot.
Murphy, E. R. F., Antigo.
Murphy, S. W., Kenosha.
Murphy, W. J., Milwaukee.
Murphy, W. T., Wankesha.
Mnth, Carl, Sheboygan.
Myers, C. E., Milladore.
Myrick, A. L., Eastman.
Nadeau, A. T., Marinette.
Nadeau, E. G., Green Bay.
Nainka, A., Boaz.
Nair, Belle P., Winnebago.
Nason, W. C., Long Beach, Cal.
Nauth, D. F., Kiel.
Nedry, G. C., Menomonie.
Nedry, H. M., Medford.
Nelson, A. L., Racine.
Nelson, A. N., Clear Lake.
Nelson, N. O., Madison.
Nelson, O. A., Park Falls.
Nelson, O. O., Arcadia.
Nelson, W. V., Milwaukee.
Netvig, G. A., Prairie Farm.
Newell, Frank, Burlington.
Newman, E. C., Berlin.
Newman, Robt., Chicago.
Newton, J. E., Hudson.
Nichols, F. C., Wausau.
Nichols, R. M., Sheboygan Falls.
Nichols, W. T., Milwaukee.
Nicholson, J. D., Milltown.
Nielson, G. W., Milwaukee.
Nielson, W. H., Milwaukee.
Nimocks, Sara, La Crosse.
Nims, C. A., Oshkosh.
Nixon, H. G. B., Hartland.
Nixon, R. T. A., Brookfield.
Noble, J. B., Waukesha.
Nohles, B. O., Milwaukee.
Noer, Julins, Riverside, Cal.
Noer, P. J., Wabeno.
Nolan, W. N., Kaukauna.
Nolte, L. G., Milwaukee.
North, C. E., Beaver Dam.
Nothohm, W. R., Dousman.
Nott, G. W., Racine.
Nowack, L. H., Watertown.
Noyes, G. B., Stone Lake.
Nuznm, Frank, Janesville.
Nuzum, T. W., Janesville.
Nuzum, W. F., Baraboo.
Nye, F. T., Beloit.
Nystrum, C. E., Medford.
O'Brien, H. J., Los Angeles, Cal.
O'Brien, H. N., Darien.
O'Brien, J. M., Oregon.
O'Brien, T., St. Nazianz.
O'Brien, W. T., Ashland.
O'Connell, D. C., Milwaukee.
O'Connell, J., Watertown.
O'Connell, J. E., Milwaukee.
O'Conner, W. F., Ladysmith.
O'Leary, T. J., East Troy.
O'Leary, T. J., Superior.
Oakland, H. G., Milwaukee.
Oatway, W. H., Waukesha.
Oberembt, B., Milwaukee.
Obertin, C. A., Union Grove.
Oettiker, Jas., Platteville.
Ogden, H. Y., Milwaukee.
Oliver, C. H., Boyceville.
Oliver, T. J., Green Bay.
Olmsted, A. O., Green Bay.
Olson, A. K., Ettrick.
Olson, A. L., Stoughton.
Olson, E. A., Osseo.
Omsted, N., Stoughton.
Orchard, H. J., Superior.
Orr, E. D., Mt. Hope.
Orton, Susanne, Darlington.
Overbaugh, J. H., Hartland.
Ovitz, E. G., Laona.
Ozanne, I. E., Neenah.
Ozanne, J. T., Oshkosh.
Packard, C. D., Rhinelander.
Pake, S. G., Hayward.
Palm, C. A., Kenosha.
Palmer, C. W., Cassville.
Palmer, J. A., Arcadia.
Palmer, W. H., Janesville.
Panetti, E. J., Milwaukee.
Panetti, P. A., Hustisford.
Parham, G. H., Necedah.
Park, W. H., Glenwood City.
Parke, Geo., Viola.
Parker, A. S., Clinton.
Parker, T. G., Rome.
Parmenter, E. L., Mondovi.
Parmley, J. P., Mineral Point.
Partridge, O. F., Mattoon.
Paschen, J. G., Milwaukee.
Patek, A. J., Milwaukee.
Payne, A. L., Eau Claire.
Peairs, R. P., Normal, Ill.
Pearce, W. J., Dodgeville.
Pearson, C. M., Ogema.
Pearson, L. M., Tomahawk.
Pease, W. A., Jr., Rio.
Pease, W. A. Sr., Otsego.
Peck, W. W., Darlington.
Peebles, Mary, Shullsburg.
Peehu, F. G., Corliss.
Pegram, J. W., Milwaukee.
Pelton, L. H., Waupaca.
Pember, J. F., Janesville.
Pembleton, W. C., Wittenberg.
Perrin, G. H., Menomonee Falls.
Perrin, H. E., Star Prairie.
Perry, Gentz, Amery.
Peters, H. A., Oconomowoc.
Peterson, C. F., Independence.
Peterson, E. F., Wauwatosa.
Peterson, G. E., Waukesha.
Peterson, R. O., Racine.
Petzke, E. A., Hixton.
Pfeffer, E. N., Milwaukee.
Pfeifer, C. W., Sheboygan Falls.
Pfeifer, F. J., New London.
Pfeifer, H. A., Jackson.
Pfeil, R. C., Bowler.
Pfeiler, A. G., Sheboygan Falls.
Pfister, Franz, Milwaukee.
Pfisterer, F. W., Markesan.
Phaneuf, S. J., Somerset.
Phillips, Clara M., Madison.
Phillips, L. J., Weyerhauser.
Phillips, T. C., Milwaukee.
Pickering, C. R., Muscoda.
Pickett, S. L., Bayfield.
Pierson, P. R., Readstown.
Pinkerton, W. T., Prairie du Chien.
Pitz, M. N., Neenah.
Pleyte, A. A., Wales.
Pomainville, Frank, Grand Rapids.
Pomainville, Geo., Nekoosa.
Pope, F. J., Racine.
Pope, F. W., Racine.
Poppe, Alfred, Friendship.
Poppe, H. B. B., Wautoma.
Poser, E. M., Columbns.
Post, C. C., Barron.
Potter, J. Y., New London.
Potter, L. A., Superior.
Potter, R. P., Marshfield.
Powell, J. J. Galesville.
Powers, C. D., Kingston.
Powers, H. W., Milwaukee.
Powers, J. W., Burlington.
Pratt, Maud, Appleton.
Prces, G. W., Cambria.
Pretts, W. W., Platteville.
Prince, L. H., Madison.
Pritchard, J. F., Manitowoc.
Proctor, T. C., Sturgeon Bay.
Pronty, W. A., Burlington.
Pugh, G. A., Kenosha.
Pugh, Wm., Kenosha.
Pullen, A. J., No. Fond du Lac.
Puls, A. J., Milwaukee.
Pnrcell, H. E., Madison.
Purdy, A. H., Milwankee.
Pnrtell, E. J., Milwaukee.
Purtell, J. A., Milwaukee.
Pynn, R. C., Delavan.
Quam, Jacob, Deerfield.
Quick, E. W., Milwaukee.
Quinn, F. J., Milwaukee.
Qninn, R. B., Darlington.
Raasock, H., Nelsonville.
Racek, G. J., Princeton.
Radloff, A. C., Plymouth.
Ragan, W. J., Shawano.
Randall, A. J., Kenosha.
Randall, M. W., Blue River.
Rantz, W. L., Rosholt.
Rasmussen, Hans, Milwaukee.
Rath, R. R., Granton.
Rathert, E. T., Chilton.
Ravn, M., Merrill.
Raymond, R. G., Brownsville.
Reo, A. L., Chippewa Falls.
Read, Flora, Fond du Lac.
Reagles, Robt., Arlington.
Reay, G. R., La Crosse.
Rector, A. E., Appleton.
Redelings, T. J., Marinette.
Reeve, J. S., Appleton.
Reeves, S. T., Albany.
Regan, E. D., Milwaukee.
Rehorst, J. J., Fond du Lac.
Reich, H. C., Sheboygan.
Reich, W. F., Milwaukee.
Reichert, J. E., West Bend.
Reineck, C., Appleton.
Reineking, H., Milwaukee.
Reinert, E. N., Cleveland.
Reinhardt, J. P., Fountain City.
Reinhart, D. B., Merrill.
Reis, G. W., Junction City.
Remer, W. H., Chaseburg.
Reynolds, J. C., Lake Geneva.
Rheineck, A. F., Milwaukee.
Rhode, H. P., Green Bay.
Rice, C. W., Delavan.
Rice, D. B., St. Paul, Minn.
Rice, D. S., Stevens Point.
Rice, E. M., Milwaukee.
Rice, F. A., Delavan.
*Rice, R. H., Delavan.
Rice, R. H., Milwaukee.
Richards, C. A., Rhinelander.
Rick, J. B., Mishicott.
Ridgman, A. L., Grand Rapids.
Ridgway, E. T., Elkhorn.
Ridley, S. R., Mineral Point.
Riehl, F. W., Milwaukee.
Riley, E. A., Park Falls.
Riley, P. E., Eau Claire.
Ringo, H. F., Montreal.
Rinker, F. C., Madison.
Riopell, W. G., Stanley.
Riordan, J. F., Berlin.
Ripley, G. H., Kenosha.
Ripley, H. M., Kenosha.
Risher, F. O., Shell Lake.
Ritchie, G. A., Appleton.
Robb, E. H., Sturgeon Bay.
Robb, J. J., Green Bay.
Roberts, D. W., Milwaukee.
Roberts, J. A., Portage.
Robinson, H. A., Kenosha.
Roby, H. S., Milwaukee.
Rock, J. N., Milwaukee.
Rodermund, A. M., Athens.
Roethke, R. W., Milwaukee.
Rogers, A. W., Milwaukee.
Rogers, E. H., Stevens Point.
Rogers, F. C., Oconomowoc.
Rogers, P. F., Milwaukee.
Rohr, J. H., North Milwaukee.
Rolfs, T. H., Milwaukee.
Rollefson, C. J., Superior.
Rood, J. F., Darien.
Rose, Felix, Coleman.
Rose, J. F., Lena.
Rosenberry, A. B., Wausau.
Rosenheimer, M. A., Fox Lake.
Rosenthal, Geo., Milwaukee.
Rosholt, J. A., La Crosse.
Ross, G. L., Kenosha.
Ross, H. R. T., Ladysmith.
Ross, J. M., Bloom City.
Ross, P. M., Milwaukee.
Rothman, L., Wittenberg.
Rouse, H. A., Browntown.
Rowles, J. A., La Crosse.
Rowley, A. G., Middleton.
Ruckle, W. M., Grand Rapids.
Ruethen, K. A., Ridgeland.
Rugh, R. E., Racine.
Ruhland, G. C., Milwaukee.
Rundell, Annie S., Beloit.
Rupp, L. G., Sullivan.
Rupp, P. H., Milwaukee.
Ruschaupt, L. F., Milwaukee.
Russell, F. G., Milwaukee.
Russell, H. C., Milwaukee.
Ryan, C. E., Appleton.
Ryan, E., Sheboygan.
Rydell, C. B., Superior.
Salter, H. G., Cascade.

*Deceased.

Sandborn, M. J., Appleton.
Sandin, N. V., Amery.
Sarazin, F. C., Superior.
Sargent, J. C., Milwaukee.
Sarles, W. T., Sparta.
Sarvela, H. L., Superior.
Sathe, M. R., Rio.
Sattre, O. M., Rice Lake.
Sauerhering, D. L., Wausau.
Saunders, Geo., Superior.
Sauter, S. H., Racine.
Sauthoff, Aug., Mendota.
Sauthoff, Mary, Mendota.
Savage, G. F., Pt. Washington.
Savage, G. T., Milwaukee.
Sayle, R. G., Milwaukee.
Sayles, L. W., Baraboo.
Saylor, Herbert, Merrill.
Scantleton, J. M., Sparta.
Schaefer, C. O., Racine.
Schallern, Bruno, Ripon.
Schaper, H., Appleton.
Schee, John, Westby.
Scheid, M. M., Rosendale.
Schein, J. E., Oshkosh.
Schell, Ida L., Milwaukee.
Scheurich, L. G., Tomah.
Schiek, I. E., Rhinelander.
Schiller, L., Milwaukee.
Schlegel, H. T., Wausau.
Schlesselman, G. H., Fond du Lac.
Schlueter, U. A., Milwaukee.
Schmeling, A. F., Columbus.
Schmidt, E. S., Green Bay.
Schmidt, F. M., Eagle.
Schmidt, H. E., Milwaukee.
Schmidt, J. A., Brillion.
Schmlt, A. I., Beloit.
Schmitt, F., Milwaukee.
Schmitt, G., Milwaukee.
Schmitt, Louis, Milwaukee.
Schmitt, Phil., Milwaukee.
Schmitz, W. C., Kiel.
Schneider, F., New London.
Schneider, J. F., Oshkosh.
Schneider, Jos., Milwaukee.
Schnell, W. H., Superior.
Schoen, C., Milwaukee.
Schoen, R. E., Beaver Dam.
Scholz, G. M., Milwaukee.
Schoofs, J. J., Malone.
Schram, C. F. N., Belolt.
Schreiner, J. K., Westby.
Schriber, E. L., Caledonia.
Schroeckenstein, R. S., Marion.
Schroeder, E. L., Shawano.
Schroeder, H. F., Marinette.
Schroeder, J. C., Milwaukee.
Schuldt, C. M., Platteville.
Schulz, F. M., Wauwatosa.
Schwalbach, C. G., Juneau.
Schwart, D. R., Chetek.
Schwartz, A. B., Milwaukee.
Schweitzer, G. J., St. Cloud.
Scollard, J. T., Milwaukee.
Scott, B. E., Berlin.
Scott, H. E., Argyle.
Scott, J. R., Appleton.
Seaman, G. E., Milwaukee.
Searle, D. R., Superior.
Sears, H. B., Beaver Dam.
Seeger, S. J., Milwaukee.
Seelman, J. J., Milwaukee.
Seemann, W. O., Eau Claire.
Seibertb, J., Lugerville.
Seidel, J. G., Warrens.
Seiler, G. A., Monroe.
Seldon, W. B., Thorp.
Senn, C. U., Ripon.
Senn, F. C., Osbkosh.
Senn, Geo., De Pere.
Senn, U., Milwaukee.
Sexton, W. G., Marshfield.
Shafferzick, Chas., Denver, Col.
Shaw, A. O., Ashland.
Shaw, B. W., Waunakee.
Shaw, J. L., Manitowoc.
Shaykett, F. E., Brandon.
Shearer, A. T., Edgerton.
Shearer, F. E., Edgerton.
Shearer, R. D., Milwaukee.
Sheehy, T. J., Tomah.
Sheldon, C. S., Madison.
Sheldon, W. H., Madison.
Shepherd, W. A., Seymour.
Sherman, Adin, Winnebago.
Sherwood, M. W., Milwaukee.
Shimek, A. J., Manitowoc.
Shinnick, T. F., Beloit.
Shippy, V. J., Stevens Point.
Shockley, H. O., Darlington.
Sholdski, J., Milwaukee.
Sibree, H. C., Sturgeon Bay.
Sickles, W. A., Milwaukee.
Sieker, A. W., Franklin.
Siekert, H. P., Milwaukee.
Sifton, H. A., Milwaukee.
Silverthorn, F. R., Berlin.
Simon, L. J., Horicon.
Simons, N. S., Taylor.
Simpson, J. E., Endeavor.
Sincock, H. A., Odanah.
Sizer, E. M. A., Chicago, Ill.
Skemp, A., La Crosse.
Skwor, C. J., Neosho.
Sleyster, Rock, Waupun.
Smedal, G., La Crosse.
Smieding, Geo., Mineral Point.
Smiles, C. J., Ashland.
Smith, A. D., Gilmanton.
Smith, C. C., Carson Lake, Minn.
Smith, C. E., Beloit.
Smith, C. M., Jr., Evansville.
Smith, D. S., La Crosse.
Smith, E. A., Milwaukee.
Smith, E. V., Fond du Lac.
Smith, G. L., Jefferson.
Smith, G. M., Chippewa Falls.
Smith, J. C., Beloit.
Smith, Jos. F., Wausau.
Smith, J. W., Milwaukee.
Smith, K. W., Madison.
Smith, O. E., Mukwonago.
Smith, R. C., Superior.
Smith, S. M., Milwaukee.
Smith, S. M. B., Wausau.
Smith, T. D., Neenah.
Smith, W. P., Waupun.
Solberg, A. A., Coon Valley.
Soles, F. A., Spencer.
Sonnenburg, C. N., Sheboygan.
Sorensou, S., Racine.
Southwick, F. A., Stevens Point.
Spawn, M. G., Beloit.
Speck, J. T., Park Falls.
Spencer, L. E., Wausau.
Sperry, S. B., Milwaukee.
Sperry, W. P., Phillips.
Spiegelberg, E. H., Boscobel.
Spitz, M. M., Milwaukee.
Stack, G. F., Independence.
Stack, S. S., Milwaukee.
Staehle, Max, Manitowoc.
Stalker, H. J., Kenosha.
Stanley, W. S., Milwaukee.
Stannard, G. H., Sheboygan.
Starnes, Brand, Mauston.
Starr, F. W., Stanley.
Stebbins, W. W., Madison.
Steele, G. A., Poynette.
Steele, G. M., Oshkosh.
Steffen, I. D., Antigo.
Steffen, L. A., Antigo.
Stemper, Irene G., Milwaukee.
Stephenson, W. L., Ladysmith.
Stevens, F. E., Bristol.
Stewart, F. W., Oconto Falls.
Stiles, F. P., Sparta.
Stiles, V. W., Sparta.
Stirn, F. J., Iron Ridge.
Stockman, B. G., Woodville.
Stoddard, C. H., Milwaukee.
Stoelting, C. W., Oconto.
Stoland, I., Eau Claire.
Stoltz, C. E., Milwaukee.
*Stormont, C. J., Viola.
Stovall, W. D., Madison.
Stove, J. P., Theresa.
Stratton, F. A., Milwaukee.
Strauss, F., Milwaukee.
Stubenvoll, C. E., Shawano.
Studley, F. C., Milwaukee.
Stuesser, C. N., Oconomowoc.
Suiter, F. C., La Crosse.
Sullivan, A. G., Madison.
Sullivan, J. D. Kenosha.
Sullivan, J. T., Milwaukee.
Sure, J. H., Milwaukee.
Surenson, M., Viroqua.
Sutherland, C. H., Janesville.
Sutherland, F. E., Janesville.
Sutter, E. H., Milwaukee.
Suttle, H. J., Viroqua.
Swarthout, E. C., La Crosse.
Sweemer, Wm., Milwaukee.
Sweetman, R. H., Green Bay.
Sykes, H. D., Milwaukee.
Sykes, L. G., Milwaukee.
Sylvester, H., Livingston.
Tanner, E. E., Milwaukee.
Tanner, G. F., Turtle Lake.
Tanner, H. B., San Antonio, Tex.
Tarnutzer, B. C., Beaver Dam.
Tarter, J. W., Iron River.
Tasche, C. T., Sheboygan.
Tasche, J. T., Sheboygan.
Taugher, A. J., Milwaukee.
Taugher, J. P., Milwaukee.
Taylor, A. R., Brodhead.
Taylor, E. A., Racine.
Taylor, F. B., Madison.
Taylor, J. G., Milwaukee.
Taylor, L. L., Waupun.
Taylor, R. W., Pewaukee.
Taylor, W. A., Portage.
Teitgen, A., Manitowoc.
Tenny, J. S., Alma.
Terhorst, H., Milwaukee.
Terlinden, J. H., Bonduel.
Teschan, R. C., Milwaukee.
Thackery, R. C., Racine.
Tharinger, E. L., Milwaukee.
Thayer, F. A., Beloit.
Thielke, G. A., Wausau.
Thienhaus, C. O., Milwaukee.
Thill, D. P., Milwaukee.
Thomas, J. S., Milwaukee.
Thomas, W. O., Clinton.
Thompson, A. S., Mt. Horeb.
Thompson, B. V., Oshkosh.
Thompson, F. A., Milwaukee.
Thompson, G. E., Kenosha.
Thompson, I. F., Eau Claire.
Thompson, J. B., Wittenberg.
Thompson, R. D., Reedsburg.
Thompson, W. L., Sheboygan.
Thomson, W. J., Portage.
Thorndike, Wm., Milwaukee.
Thorne, J. P., Janesville.
Tibbits, U. J., Waukesha.
Tiedemann, E. J., De Sota.
Tillson, E. M., Milwaukee.
Timm, E. W., Milwaukee.
Tisdale, L. C., Milwaukee.
Tkadlec, Jos., Lime Ridge.
Tompach, Emil, Racine.
Tormey, T. W., Madison.
Torpy, T. G., Minoqua.
Towne, W. H., Shiocton.
Townsend, E. H., La Crosse.
Townsend, E. H., Sr., New Lisbon.
Townsend, Elma J., Madison.
Tranckle, H. M., Bloomer.
Treadwell, C. L., Kilbourn.
Treat, C. R., Sharon.
Treglown, L. H., Livingston.
Trevitt, Margaret, Wausau.
Trowbridge, C. H., Viroqua.
Trowbridge, Wm., Viroqua.
Tryon, F. E., Merrimac.
Tuffley, F. S., Boscobel.
Tupper, E. E., Eau Claire.
Twohig, D. J., Fond du Lac.
Twohig, H. E., Fond du Lac.
Twohig, J. Elmer, Fond du Lac.
Tyvand, J. C., Whitehall.
Uren, Andrew, Montreal.
Urbeim, O. J., Park Falls.
Urquhart, C. C., Hurley.
Valentine, L. P., Milwaukee.
Van Altena, Jr., L. A., Cedar Grove.
Van der Lind, L. A., Muskegon, Mich.
Van der Ven, J. M., Hales Corners.
Van Hengel, G. L., Waupun.
Van Kirk, F. W., Janesville.
Van Schaick, R. E., Caroline.
Van Valzah, Robt., Madison.
Van Zanten, Wm., Sheboygan.
Vedder, J. B., Marshfield.
Verbeck, S. F., Lodi.
Ver Meulen, J. R., Waupun.
Vernon, S. G., Madison.
Vogel, C. A., Elroy.
Vogel, C. C., Elroy.
Voight, A. H., Oostburg.
Voje, J. H., Oconomowoc.
Von Beust, M., Milwaukee.
Von Buddenbrock, E., Racine.
Von Neupert, Carl, Jr., Stevens Point.
Von Neupert, Carl, Sr., Stevens Point.
Vosburg, W. H., Cooperstown.
Voskuil, Anthony, Cedar Grove.
Wade, F. S., New Richmond.
Wadey, B. J., Belleville.

*Deceased.

Wagner, N. B., Racine.
Wahl, C. M., Spring Green.
Wahl, H. S., Wausau.
Waite, W. S., Kendalls.
Wakefield, G. F., West Salem.
Wakefield, S. R., West Salem.
Walbridge, F. E., Stevens Point.
Walbridge, J. S., Berlin.
Walch, F. C., Black Creek.
Waldschmidt, J. W., Fond du Lac.
Waldschmidt, W. J., Fond du Lac.
Walker, F. W., St. Croix Falls.
Walker, L. G., Pound.
*Wall, H. J., Richland Center.
Walsh, C. C., Merrill.
Walters, D. N., Campbellsport.
Warfield, L. M., Milwaukee.
Was, Edward, Oostburg.
Washburn, R. G., Milwaukee.
Washburn, W. H., Milwaukee.
Waters, Don, Grand Rapids.
Waters, Hugh, Nekoosa.
Watson, F. V., Antigo.
Waufle, G. C., Janesville.
Weaver, L. A., Iron Belt.
Webb, E. P., Beaver Dam.
Webb, W. B., Beaver Dam.
Weber, A. J., Milwaukee.
Weber, H. F., Newburg.
Webster, B. N., Rice Lake.
Webster, F. E., Amherst.
Wegge, W. F., Milwaukee.
Wehle, W. J., West Bend.
Weideman, W. G., Milwaukee.
Weidner, M. C., Milwaukee.
Weingart, W. F., Milwaukee.
Welch, F. B., Janesville.
Welch, T. R., Rhinelander.
Weld, H. J., Campbellsport.
Wenn, J. F., Milwaukee.
Wenstrand, D. E., Milwaukee.
Wenker, R. J., Milwaukee.
Wentzell, W. L., Stoughton.
Wenzel, J. V., Ashland.
Werner, C. F., St. Cloud.
Werner, H. C., Union Grove.
Weruer, Nels, Barron.
Werner, R. F., Eau Claire.
Westgate, H. J., Rhinelander.
Westhofen, R. C., Milwaukee.
Westphal, H. G., Polar.
Wetzler, S. H., Milwaukee.
Wheeler, W. P., Oshkosh.
White, A. G., Milwaukee.
White, A. S., Rice Lake.
White, R. M., Prairie du Chien.
White, W. E., Burlington.
Whitehorn, E. E., Vesper.
Whiteside, G. D., Plover.
Whitney, D. C., Rice Lake.
Whyte, W. F., Madison.
Wichman, G. C., Rib Lake.
Wiesender, A. J., Berlin.
Wiger, H. C., Dallas.
Wilcox, A. G., Solon Springs.
Wiley, F. S., Fond du Lac.
Wilkinson, J. A., Hales Corners.
Wilkinson, M. R., Oconomowoc.
Wilkowski, C. W., Chippewa Falls.
Willard, L. M., Wausau.
Williams, A. J., Waukesha.
Williams, H. H., Sparta.
Williams, Maude R., Milwaukee.
Williams, R. L., Statesan.
Williams, S. E., Chippewa Falls.
Williams, W. B., Argyle.
Williams, W. E., Cambria.
Williamson, G. H., Neenah.
Wilmarth, A. W., Chippewa Falls.
Wilson, C. J., Milwaukee.
Windesheim, G., Kenosha.
Wiug, W. S., Oconomowoc.
Wiuneman, F. A., Merrill.
Wiuslow, F. R., Baraboo.
Winter, A. E., Tomah.
Witepalek, W. W., Algoma.
Witte, D. H., Hartford.
Witte, W. C. F., Milwaukee.
Woehos, F. J., Green Bay.
Wochos, W. M., Kewaunee.
Wolf, H. E., La Crosse.
Wolff, J., Milwaukee.
Wolfgram, O. J., Lyons.
Wolter, H. A., Green Bay.
Wolters, H. F., Milwaukee.
Wood, F. C., Waupaca.
Woodhead, F. J., Merton.
Wright, A. E., New Richmond.
Wright, C. A., Delavan.
Wright, F. R., West Allis.
Wright, J. C., Antigo.
Yaffe, Aaron, Milwaukee.
Yanke, A. E., Milwaukee.
Yates, C. A., Bangor.
Yates, J. L., Milwaukee.
Youmans, L. E., Mukwonago.
Young, A. F., Wauwatosa.
Young, G. H., Elkhorn.
Young, J. H., Elkhorn.
Young, M. L., Ashland.
Young, Will, Ft. Atkinson.
Zaun, G. F., Milwaukee.
Ziegler, E. J., Oxford.
Zierath, W. F., Sheboygan.
Zilisch, W. E., Wausau.
Zimmerman, Amelia, Kenosha.
Zimmermann, C., Milwaukee.
Zinns, A. J., Milwaukee.
Zivnuska, J. F., Milwaukee.
Zohlen, J. P., Sheboygan.
Zuercher, J. C., La Crosse.
Zwickey, W. H., Superior.

*Deceased.

ANNUAL REPORT OF THE SURGEON GENERAL.

The Annual Report of the Surgeon General, U. S. Army, for 1918, (including statistics for the calendar year 1917 and activities for the fiscal year ending June 30, 1918), has just been issued from the Government Printing Office. It contains a comparative study of the health of the Army, 1820-1917; an account of the health of the mobilization camps and of the Army by countries; a consideration (70 pages in extent) of the principal epidemics in the camps; and a discussion of fractures and operations. Nearly 200 pages are devoted to the special activities of the medical department—with the American Expeditionary Forces, and in the divisions of sanitation, hospitals, supplies, laboratories and infectious diseases, internal medicine, general surgery, orthopedics, head surgery, neurology and psychiatry, psychology, food and the Dental and Veterinary corps. In addition to the usual tables of illness, discharge for disability and death, there are given tables of battle wounds and operations; of complications of various diseases and of case mortality. The text is illustrated by 73 charts. Altogether the report is a study of health and morbidity in an Army of over 1,500,000 men, for the most part yet in the period of training. It should be of interest to epidemiologists, vital statisticians and army medical men.

DISCONTINUES "COUNTER-PRESCRIBING."

The profession will no doubt be interested in the recent announcement of The Owl Drug Co. stating that beginning December 1st, no preparations for the self-treatment of venereal diseases will be sold in the 29 retail stores of the company, located on the Pacific Coast and in the Middle West.

When such preparations are called for, the salesman is instructed to explain the new policy of the company and give the customer a carefully prepared confidential circular, which explains the seriousness of all venereal diseases and the importance of consulting a reliable physician and a list of such will be furnished upon request.

Standard preparations, recognized by the profession will be carried in the prescription room and sold only upon orders from a physician.

Some weeks previous to this announcement the laboratories of The Owl Drug Co. discontinued the manufacture of several preparations for self-treatment.

This innovation was decided upon after the management gave due consideration to the report of the Surgeon General of the U. S. Army showing an alarming prevalence of venereal diseases among the civilians who were examined preparatory to entering the army.

The action of other druggists will be awaited with interest.

PARAGRAPHS AND SLOGANS.

In England they say, "Every shilling wasted stabs a soldier in the back."

If you actually knew that by buying only those things you absolutely needed and by putting your savings into War Savings Stamps you could save lives, would you do it? Take the word of the President that you do save lives when you do this.

It is not enough to deplore what the Germans have

done. That will not hurt the Germans; they don't care what you think of them. Help your Government to fight them. That is the only thing that counts with a German. When you save and buy War Savings Stamps you attack a German in the place where it hurts.

Everyone knows best how he can reduce his expenses so that he may have more savings with which to buy War Savings Stamps.

Prof. T. N. Carver, of Harvard University, says: "Anyone who, in these days of impending doom, buys anything which he does not need for his health, strength, or efficiency is hiring some one to do something which is unnecessary. He is hiring some one to stay out of the essential industries. He is competing with the Government for materials and man power which it needs to win the war and preserve the liberties of mankind."

Some one has said: "If one of our boys hesitated as long in going over the top as some people do in buying Liberty bonds or War Savings Stamps, he would be court-martialed and shot for cowardice. And if the same punishment were meted out to noncombatants for financial cowardice an awful lot of people would be shot at dawn."

We are not going to lose the war, but did you ever stop to think what would happen to us if we did lose it? The speed with which we win it depends upon the way you and I save and give the Government our financial support. Buy W. S. S. for a quick victory.

Your part in the war is to produce as much as possible, consume as little as necessary, and loan your savings to the Government. Are you facing your task as cheerfully as our fighting men face theirs?

If you despise what the Germans do, let your savings help fight them.

He is a poor sort of a patriot who can not find some way to economize in order that he may buy War Savings Stamps, and in so doing give the Government more money, labor and materials with which to fight the war.

MORE SHIPS FROM HEALTHIER WORKERS.

Draining marshes, cleaning cities, and examining and re-examining hundreds of thousands of men, would seem, to the casual observer, a peculiar way to expedite the building of ships. This, however, is one of the ways adopted by the government to increase the production of ships and conserve the health of the shipbuilders.

An article in *The Modern Hospital* explains how the standards of surgical and medical attention for shipbuilders are being enforced, under the supervision of Lieut.-Col. Philip S. Doane, M. C., N. A., director of health and sanitation for the United States Shipping Board Emergency Fleet Corporation.

Colonel Doane is responsible not only for the first aid and surgical treatment, but he must also see that the men in 171 shipyards scattered along the entire coast length of the Atlantic, Pacific, Gulf, and Great Lakes, of this country, live and work under sanitary and healthful conditions.

Everywhere ships are being built for the government, Colonel Doane makes it his business to see that the men are well housed, have clean restaurants, and a pure water supply; that they receive competent medical and surgical attention, and that an educational campaign is instituted against the ravages of venereal disease.

ONE MORE AMERICAN HONORED BY FRANCE.

No battle in France is fought with greater earnestness than that being waged against tuberculosis. Shortage of food, congested housing, overwork, and other attendant evils of war, have all been conducive to an alarming increase in tuberculosis among the refuges of France. Little bands of homeless cling to each other, refusing to be separated from their sick, while they hopefully await the day when they may return to their former homes. "To provide for these," writes Dr. William Charles White in *The Modern Hospital*, "we took the Malaby estate and opened a 'school for housing.' In planning Malaby we aimed to create an organization that would be of subsequent value in the reconstruction era. Each houseless refugee family with a consumptive member is given a small wooden house fitted out anew; the whole family, well or sick, will be under constant medical supervision, and when the war ends the family will be sent back, house, equipment and all, to the village of its choice, with the new and priceless knowledge of how to live with a tuberculosis member in the household to care for him and to protect others. They will be taught new trades, if necessary, and the children will be taught by teachers of the French department of education in open air schools."

This entire group of activities, caring for fifteen hundred refugees in whom tuberculosis is a common factor, has been named the Edward L. Trudeau Institution as a memorial to that courageous American who devoted forty years of his life to the fight against this disease.

THE LIBRARY AND THE READING ROOM.

The books and periodicals of the Berks County Medical Society have been resurrected from chaos and moved into the new home, where they are now awaiting the efforts of the members to put them in a workable condition. Our library at the present time is of no mean proportion.

An order has been placed for covering the floors in the library and reading rooms. When this has been accomplished, the work of arranging the books will proceed.

Much work remains to be done, work that will, however, repay those who care to assume the burden. We would urge the younger members to lend their assistance in this matter. In no better way can anyone become acquainted with the library than by actually handling the books—*Bulletin*, Berks County (Pa.) Medical Society.

THE WISCONSIN MEDICAL JOURNAL
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ROCK SLEYSTER, M. D., Editor
Waupun

J. P. McMAHON, Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:

OSCAR LOTZ, M. D., Milwaukee
JOS. SMITH, M. D., Wausau
HOYT E. DEARHOLT, M. D., Milwaukee
ROCK SLEYSTER, M. D., Waupun
S. S. HALL, M. D. Ripon

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EDITORIALS

1919

The Journal extends to the members of its family best wishes for a Happy and Prosperous New Year. Never has a new year been fraught with greater opportunity—opportunity which points the way to success in practice and to success in service.

The final curtain has been rung down on the greatest of all world tragedies. In bringing about the happy ending in which Justice and Right have triumphed over the hellish spectre that has threatened civilization for the past four years, the profession to which we belong has played no minor part. The great service flag of the State Medical Society of Wisconsin with its nearly 800 stars symbolizes to us today not only service and victory but a reverent thankfulness that the war is ended and a gratitude to the medical men of Wisconsin who went forward at the call. It is to them and the brave lads to whom they ministered that we owe the right to lift our heads again in the calm assurance of Liberty, Opportunity and Peace.

The organization rejoices today that those who left our ranks at the call of a higher duty will soon be back again. Let us make every effort to aid them in a prompt renewal of their former business and professional relationships.

And now they are coming home—all but a few—a few who made the big sacrifice and gave their all. Let their memory strengthen a New Year's resolution to aim for bigger, higher things the coming year.

THE JANUARY NUMBER.

THE January number of the Journal is almost entirely given to the publication of the Proceedings of the last House of Delegates. This is the legislative body of your society. It transacts the business of a corporation in which you are a partner and a stockholder. Its transactions should be of interest to every member who is interested in anything outside of his own little person. Your attention is especially called to the published reports of your officers and various committees.

GROUP MEDICINE.

AT the recent meeting of the American Public Health Association, in Chicago, Doctor Victor C. Vaughan stated: "I hope that there will be proper federal medical supervision for every citizen of the United States. I am inclined to believe that everyone of the 30,000 doctors who will be released from army and navy service will agree to the practice of group medicine. A man who is nationally known in medical practice and whose private practice brought him an income probably ten times that of his salary as Major, told me that if it only were possible, he would much prefer to treat his patients on the army plan."

The war has taught us many things. Not the least among them is the value of team work. Will the medical profession, engaged in the greatest of human callings, be the last group of workers to

realize that success and ideals are gained only through cooperation and that the days of competition as formerly known have gone down to oblivion with Kaiserism.

THE EPIDEMIOLOGY OF INFLUENZA.

THE recent pandemic of influenza which, so all agree, has attacked very largely members of the population both civilians and soldiers under thirty years of age, suggests a number of very interesting questions in the epidemiology of the disease. The great pandemic which struck the country between the years 1889 to 1891 attacked all members of the population indiscriminately. The concensus of opinion seems to be that the nervous and gastrointestinal manifestations were much more severe than in the present pandemic and that the mortality among older people, due to complicating pneumonia, was very much larger than in the recent pandemic.

Although the B. influenza discovered by Pfeiffer towards the end of the great pandemic in 1891 was considered by some to be the cause of the disease, nevertheless it has not been widely accepted as the real etiological agent. Since 1891 there have been a number of sporadic outbreaks throughout the country, some assuming epidemic forms, but all of these outbreaks have been of a comparatively mild type and again the elderly portion of the population has been the greatest sufferer.

The widespread belief that influenza confers no immunity is probably due to the fact that any severe cold which may be caused by a variety of organisms has been called la grippe. This term is used by many as a synoym for influenza. It is exceedingly doubtful, however, if we are justified in the use of the term la grippe or influenza except with the mental reservation that this is a disease which has no common causative factor but which has, however, a somewhat uniform symtomatology. That is to say, there is acute infection of the upper respiratory tract accompanied by more or less malaise, sometimes slight fever, and frequently by complicating accessory sinus infection. Many varieties of colds are highly infectious, spreading rapidly from person to person wherever intimate contact is present. Other colds seems to be of so low a degree of infection that they are not spread to other persons. By the almost universal custom of calling all highly infectious colds la grippe (influenza) without knowledge of the infecting agent, we have drawn the erroneous and altogether unjustifiable conclusion that one attack of influenza confers no immunity. Colds do recur frequently. Apparently there is no prolonged immunity conferred. Yet a series of colds may occur in the same person, caused every time by a different organism.

We wish to advance the proposition that an attack of epidemic influenza renders the person who recovers from it immune to further attacks. There is no disease which we know of which cannot recur in the same individual even though the general rule is that one attack of any of a number of diseases confers immunity against reinfection with that particular disease. We do not know the actual cause of epidemic influenza, but in our ignorance of the cause we are in the same position in regard to many other infectious diseases, for instance yellow fever, measles, scarlet fever. Yet we are in possession of many facts connected with the epidemiology of these diseases. We know, for example, that the history of epidemics of scarlet fever or measles is one of waves. That is to say, in any given center of population there are years when the number of cases increases to epidemic proportions followed by a few years during which only a few cases occur. This is explainable when one considers that the material to be infected, composed for the greater part of children, must reach a certain number of unattacked children before there is sufficient soil, so to speak, for the epidemic to flourish upon. A comparison between the first pandemic of influenza and a virgin population attacked by measles brings out certain striking facts. We have records of sea islands to which measles has been introduced among the population and which has produced frightful mortality among all members of the population. The most classic example of this is the introduction among the Terra del Fuego indians of measles brought by a British trading ship. The further history of this population is not known to the writer, but from what is known of infectious diseases it is reasonable to suppose that an epidemic which might have occurred in that place twenty years later would have attacked only the young members of the population. The others would have been immune.

Now it will be recalled that it was 28 years ago since the great pandemic swept this country. At that time, it has been said there was almost universal infection. In 28 years many thousands of

the population, young and old, have died from other causes, and in that 28 years an entirely new, fresh crop of adults and children have grown up.

The interesting and important fact to be borne in mind is that the present epidemic attacked, with comparatively few exceptions, members of the population under 30 years of age, and while there are no statistics available in regard to the number of older people who had influenza in 1889-91 who recently had a second attack, we may suppose that the number was not many in view of the enormous number of young people who made up almost entirely the mortality records. Arguing on this basis it would appear that true epidemic influenza, a disease the cause of which is at present unknown, does produce immunity. The fact that the epidemic was so widespread among the young adults and children of the population who were not born at the time of the great pandemic lends weight to the argument that this fresh soil was that upon which the infecting agent found its best opportunity for growth.

It seems to us that the evidence at hand can lead to no other conclusion. Epidemic influenza then is an acute infectious disease of unknown causation, which confers immunity upon the person attacked. This immunity apparently lasts through life. It is quite analagous to such diseases as measles and scarlet fever, responds to exactly the same laws, and therefore what holds for measles and scarlet fever holds also for epidemic influenza.

L. M. W.

NOTICE.

YOUR present membership in The State Medical Society expired January 1st as did your subscription to THE WISCONSIN MEDICAL JOURNAL. Your medical defense will lapse Feb. 1st if 1919 dues are unpaid.

The only way to renew your membership and to insure the receipt of future copies of the JOURNAL is by making an immediate remittance of your 1919 dues to the secretary of your County Medical Society. *Remember he is serving without remuneration and should not be asked to expend time and energy in collecting your dues.*

Send your secretary a check TODAY;

Thereby

Contributing your share toward organized medicine in Wisconsin,

Paying your subscription to your JOURNAL.

Keeping your medical defense in force, and

Co-operating to minimize the labor of your officers.

BUSINESS! !

DUES ARE PAYABLE JAN. 1ST. THIS IS AN IMPORTANT MATTER FOR YOU TO REMEMBER, FOR THE WORK OF THE SOCIETY IS GROWING IN MAGNITUDE SO FAST THAT BUSINESS PRINCIPLES MUST BE FOLLOWED. DO NOT MAKE ANY MORE TROUBLE FOR YOUR COUNTY SECRETARY THAN YOU CAN HELP—REMEMBER, HIS IS A LABOR OF LOVE AND IT IS UNFAIR TO COMPEL HIM TO DUN YOU AGAIN AND AGAIN—THEREFORE, PAY YOUR DUES PROMPTLY. ALL MEMBERSHIPS TERMINATE DECEMBER 31ST, BUT IN ORDER TO GIVE OLD MEMBERS A CHANCE TO RETAIN THEIR MEMBERSHIP, THEY ARE ALLOWED 30 DAYS IN WHICH TO BE REPORTED TO THIS OFFICE. ANY OLD MEMBER NOT REPORTED AND PAID FOR BY FEB. 1ST IS DELINQUENT AND NOT ELIGIBLE TO MEDICAL DEFENSE. HE LOSES ALL RIGHT TO DEFENSE FROM JAN. 1ST UNTIL THE TIME HE FINALLY PAYS. NO MEMBER CAN AFFORD TO BE WITHOUT DEFENSE A SINGLE DAY. BE SURE TO PAY YOUR DUES EARLY AND AVOID TROUBLE.

MEDICAL MOBILIZATION AND THE WAR

PERSONNEL OF THE MEDICAL CORPS.

For the week ending December 27, there were in the Medical Corps, 29,098 officers, a decrease of 949 since the previous week. This personnel includes four major-generals, five brigadier-generals, 221 colonels, 521 lieutenant-colonels, 2,462 majors, 9,452 captains and 16,433 lieutenants. There were in active service 28,357, a decrease of 875 since the previous week. Discharges to date include 6,231 officers.

MEDICAL DIVISION OF THE PROVOST-MARSHAL'S OFFICE DISBANDED.

The Medical Division of the Provost-Marshal's Office is being disbanded. Lieut-Col. Hubert Work and Capt. D. Chester Brown have received honorable discharges and have returned to their homes. Col. F. R. Keefer will shortly return to service with the regular Medical Corps.

THE ASSOCIATION OF THE MEDICAL VETERANS OF THE WORLD WAR.

To Commissioned Officers in the Medical Corps of the United States Army, United States Navy, United States Public Health Service, and Medical Members of the Boards of the Selective Service System:

There has been incorporated and officered, the Association of Medical Veterans of the World War, with headquarters in Washington, D. C.

All physicians and surgeons commissioned in the Medical Reserve Corps, or Medical Corps of the United States Army, United States Navy, United States Public Health Service, medical members and medical examiners of Local, Medical Advisory and District Boards officially appointed by the President, or by the governors of states, may become active members by signing the proper application and paying the nominal sum of $1.

The Association of Medical Veterans of the World War is for the purpose of perpetuating fellowships formed in the military service of the United States, 1914 to 1918; promoting reunions of medical veterans; providing a common point of contact for organization of medical men already founded or to be later instituted, who took official part in winning the world war; for advancing medical science among its members, and for protecting those in need, through declining years.

It is expected that this organization may become the medium of association with foreign societies of medical war veterans, to the end that the medical profession of nations may continue to be allied, in harmony with the governments that made common cause and secured a common victory.

Special associations of medical war veterans, with membership restricted to states, to the selective service, specialists in medicine, overseas service, etc., are invited to elect delegates to represent them in the house of representatives, to which the government of the Medical Veterans of the World War will be entrusted, through the board of directors, to be elected by this house of representatives.

The first convention of the Medical Veterans of the World War, to be held in Atlantic City, N. J., during the second week in June, 1919, will be the Victory Meeting, at which the affairs of the association will be placed in the hands of its officers, to be elected at that time.

Physicians who are qualified by service in either of the Medical Corps of the United States government or because of having served by appointment as a member of one of the boards under the selective service system, are requested to submit applications for membership, stating the branch of service in which they have been engaged, together with their membership fee ($1), to the secretary of the association, Col. Frederick F. Russell, care of the Office of the Surgeon-General of the Army, Washington, D. C.

FREDERICK F. RUSSELL, M. D.,
Washington, D. C.

Colonel, M. C., U. S. Army.

PROPOSED CHANGES IN ARMY MEDICAL CORPS.

Representative Dyer has recently proposed to amend the national defense act, as follows:

Section 1. That the medical department of the Army shall consist of one surgeon general with the rank of major general, who shall be chief of said department; assistant surgeon generals in the ratio of one-half of one per centum of the total number of officers of the medical department provided by law, the assistant surgeon generals to be equally distributed in the grades of major general and brigadier general of the medical corps, the dental corps, and the veterinary corps authorized by law, the commissioned officers of which shall be citizens of the United States, the enlisted force of the medical department of the Army as now provided by law.

Sec. 2. That commissioned officers of the medical corps below the rank of brigadier general shall be proportionately distributed in the several grades as now provided by law for the medical corps of the Navy.

Sec. 3. That hereafter the President shall be authorized to fill any vacancy that may occur in the commissioned personnel of the permanent establishment of the medical department of the Army of the United States by selection from the medical officers of the United States Army of not less than one year's continuous active service: Provided, That the selection shall be upon the efficiency rating and satisfactory examination of the officer, and where two or more officers are of equal rating selection will favor the one of longest service in the United States Army, Volunteer Army, National Guard, officers' reserve corps, or National Army: Provided further, That the officers so selected will be commissioned without loss of rank in the permanent establishment of the medical department of the Army of the United States, and such officers so commissioned shall be entitled to all pay, promotion, and allowances of officers of like rank in the permanent establishment of the Army of the United States, excepting that the rate of retirement pay shall be one-thirtieth of the present retirement pay, as now prescribed by law, for each year's service as enlisted man; or commissioned officer, or the total of such services in the United States Army, Volunteer Army, National Guard, officers' reserve corps, National Army, dental corps, dental reserve, or enlisted personnel in the Army or National Guard in any of the various departments of the Army of the United States: And provided further, That at the age now prescribed

by law for retirement an officer to receive retirement pay shall have not less than 15 years' service in any or all branches enumerated in this act: And provided further, That the provisions of this act shall in like manner govern the filling hereafter of all vacancies in the dental corps of the United States Army: And provided further: That the ratio of dental surgeons now and hereafter commissioned shall be two dental surgeons per thousand of enlisted strength of the Army of the United States: And provided further, That all laws or parts of laws, in so far as they are inconsistent with the provisions of this act, are hereby repealed.

EUROPEAN RED CROSS SURVEY.

It is announced by the American Red Cross that Major Homer Folks, formerly head of the New York State Charities Aid Association, who has been with the American Red Cross abroad since July, 1917, has been promoted to lieutenant-colonel and has been made chairman of a special mission to make a survey of the European countries in which the Red Cross is operating on which to base a comprehensive program of reconstruction. It is believed that through the rapidly changing conditions in those countries since the signing of the armistice an even larger demand may be made on the Red Cross. Investigations have already been made in Italy, and the Balkan countries will be next visited. The survey is to include Turkey, Armenia and Palestine.

DEMOBILIZATION OF OFFICERS OF THE MEDICAL CORPS.

Officers of the medical corps have received the following letter from the Surgeon General preparatory to demobilization:

1. I am directed by the Surgeon General to advise you that the present plans for the demobilization of officers of the Medical Department holding temporary commissions and who hold no Regular Army commissions, contemplate the division of such officers of the Medical Department into four classes:

First: Those desiring immediate and complete release by way of honorable discharge;

Second: Those desiring immediate release from active service and reappointment in the Officers' Reserve Corps, inactive;

Third: Those who desire to remain on duty under their present commissions as long as their services are required;

Fourth: Those desiring appointment in the Regular Army and who are considered eligible for such appointment.

2. Under existing law the maximum age limit for appointment in the Medical Corps of the Regular Army is 32 years, Dental Corps, Regular Army, 32 years and Veterinary Corps, Regular Army, 27 years. There is no provision of law for Reserve Commissions in the Sanitary Corps.

3. The Surgeon General requests that you advise the personnel division of this office immediately in which of the above classes you wish to be placed.

(Signed) C. R. Darnall,
Colonel, Medical Corps, U. S. A.,
Executive Officer.

WAR NOTES

Captain H. S. Roby of Milwaukee, assigned to base hospital No. 79, arrived overseas September 28th. He was ordered to eastern France and November 22nd wrote from an evacuation hospital just back of the lines.

Dr. J. C. Elsom, formerly in charge of physical training at the State University has been transferred from Fort Leavenworth to the Walter Reed Hospital at Washington. The Walter Reed Hospital is now being devoted entirely to work in re -construction, the line of work in which Dr. Elsom is most interested.

Lieut. J. M. Baasen, who was discharged from Camp Logan the week before Christmas, received a royal welcome on his arrival at his home in Mt. Calvary. The village was decorated with the national colors and Dr. Baasen received an all day reception.

The Sheboygan Press is authority for the news that Dr. Otto Fiedler has been given the command of base hospital No. 22, now in France.

Major E. J. Barrett of Sheboygan was called home early in December by the serious illness of his wife.

Major J. R. Longley of Fond du Lac has written his wife from Archangel, Russia.

Word has been received that Captain H. R. Beeson, formerly located at Medford, has been seriously wounded, overseas.

Major S. E. Gavin of Fond du Lac is now chief of the surgical service at Fort Sheridan, Illinois. He has recently been transferred from his station at Camp Colt.

Major Farrell of Two Rivers was home from Fort Riley to spend a few days before leaving for Newport News, Virginia, where he will help in the demobilization of a command comprised of four hospitals and sanitary trains of which he had charge and was to have taken across.

Word has been received of the promotion of Captain G. A. Bading from the rank of Captain to Major. He has been serving as an instructor in the medical department of the students officers school for the Philippine National Guard.

Lieut. W. A. Sexton of Marshfield visited at his home early in December while on his way to Fort Snelling from Camp Greenleaf, Georgia.

Dr. J. F. Schneider, after a year's service in France, returned to his home in Oshkosh at an early hour, Christmas morning.

Lieutenant W. T. Salbreiter of Racine, now overseas, has been promoted to the rank of Captain.

Lieutenant A. J. Pullen of North Fond du Lac was given a royal welcome by the residents of the village when he returned late Saturday afternoon, December 7th, from Camp Green, South Carolina. The village turned out en masse.

Dr. N. F. Crowe of Walworth is now stationed at Glasgow, Scotland.

Captain J. R. Eastman of Kenosha, now overseas, recently traveled 200 miles over the battle scarred fields of France to find his son who has been in service over there, and finally located him between Metz and Verdun. Captain Eastman is now stationed at Chaumont.

Captain J. B. Vedder of Marshfield has written his wife from Brest, France. He has been assigned to a coast hospital which cares for soldiers awaiting transportation home.

Captain F. E. Andre of Kenosha is in charge of a convalescent hospital at Hyerer, France.

In a letter received by his wife, Lieutenant D. F. Gosin of Green Bay tells of the recent fighting near the Verdun front.

Major L. M. Warfield returned from military service at Jefferson Barracks, Mo., December 13th and has associated himself with Dr. Louis F. Jermain in the practice of diagnosis and internal medicine at suite 1203 Majestic Bldg., Milwaukee.

Word has been received from France that Capt. Robert W. Blumenthal has been commissioned a major. He served with the national guard at the Mexican border. Maj. Blumenthal trained at Fort Riley, Kan., and Waco, Tex., before sailing in January with the Thirty-second division.

The contribution of Milwaukee physicians to the service of the country during the war is shown by eight pages in a book in the desk of Henry A. Verges, deputy county clerk. Here are recorded the names of 240 doctors who have asked for copies of their certificates to be used in applying for admission to the service.

Maj. J. W. Frew, Milwaukee, of the medical department, has been promoted to lieutenant colonel. He went to France fourteen months ago.

Word has been received in Milwaukee that Capt. Arthur A Mitten, who was taken prisoner by the Germans, had passed through Switzerland on Nov. 29 on his way back to his regiment. Capt. Mitten, together with seventy-two other Americans have been released from the German prison camp at Villingen and are on their way back to their comrades in France.

Capt. Clarence A. Baer, Milwaukee physician with the Red Cross overseas, was the first member of the allied armies in uniform to enter Brussels after its evacuation by the Germans.

Capt. E. L. Mason has been transferred from Camp Dodge, Ia., to a base hospital at Allentown, Pa. He was granted a short furlough to visit his wife and son at Janesville.

HONORABLE DISCHARGES, MEDICAL CORPS, U. S. ARMY.

T. J. Sheehy, Tomah.
A. J. Patek, Milwaukee.
L. M. Warfield, Milwaukee.
L. W. Sayles, Baraboo.
A. J. Pullen, North Fond du Lac.
F. Forsbeck, Milwaukee.
J. A. Heraty, Milwaukee.
C. L. R. MacCollum, Manitowoc.
John Kelly, Cato.
E. L. Mason, Eau Claire.
J. T. Corr, Racine.
H. N. O'Brien, Darien.
W. F. Whyte, Madison.
Niel Andrews, Oshkosh.
P. J. McCabe, Dotyville.
J. M. Baasen, Mt. Calvary.
R. M. Hall, Milwaukee.
F. S. Tuffley, Boscobel.
H. A. Jefferson, Clintonville.
Floyd Shearer, Edgerton.
J. F. Schneider, Oshkosh.
L. W. Dudley, Milwaukee.
F. J. Donnelly, Nashotah.
M. R. Wilkinson, Oconomowoc.
L. L. Taylor, Waupun.
F. A. Walters, Stevens Point.
E. J. Knapp, Rice Lake.
D. L. Dawson, Rice Lake.
G. E. Towle, Mosinee.
W. H. Finney, Clintonville.
J. J. Seelman, Milwaukee.
W. F. Stueck, Mishicot.
S. E. Hutchins, Whitehall.

ORDERS TO OFFICERS OF MEDICAL CORPS U. S. ARMY.

To Camp Abraham Eustis, Va., from Fort Oglethorpe, Lieut. A. J. Loughmann, Oconomowoc.

To Camp Custer, Mich., from Fort Porter, Capt. J. M. Conley, Oshkosh.

To Camp Hancock, Ga., base hospital, for instructions, from Fort Oglethorpe, Lieut. J. H. Carroll, Milwaukee.

To Camp Jackson, S. C., base hospital, from Camp Cody, Lieut. E. R. Murphy, Antigo.

To Camp Joseph E. Johnston, Fla., base hospital, for instruction, from Fort Oglethorpe, Capt. W. A. Prouty, Burlington.

To Camp Meade, Md., from Camp A. A. Humphreys, Lieut. J. M. Ross, Bloom City.

To Camp Travis, Texas, base hospital, from Camp Pike, Capt. C. O. Latham, Green Bay.

To Camp Zachary Taylor, Ky., base hospital, from Fort Oglethorpe, Lieut. W. G. Darling, Milwaukee.

To Dansville, N. Y., from Camp Custer, Capt. W. T. Kradwell, Wauwatosa.

To Fort Des Moines, Iowa, for instruction, from Fort Oglethorpe, Capt. W. A. Ladwig, Wausau.

To Fort Oglethorpe, base hospital, from Camp Zachary Taylor, Capt. B. E. Scott, Berlin.

To Fort Sheridan, Ill., for instruction, from Camp Colt, Major S. E. Gavin, Fond du Lac.

To Otisville, N. Y., from Markleton, Capt. L. W. Dudley, Milwaukee.

To Plattsburg Barracks, N. Y., from Camp Sherman, Capt. J. F. Wenn Milwaukee.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to Camp Wadsworth, S. C., base hospital, for instruction, from Fort Oglethorpe, Capt. R. W. Jones, Wausau.

The following order has been revoked: To Carlisle, Pa., from Camp Crane, Capt. W. Hecker, Beloit.

To Camp Beauregard, La., to examine the command for cardiovascular diseases, from Camp Jackson, Capt. A. J. Patek, Milwaukee.

To Camp Devens, Mass., base hospital, from New Haven, Lieut. F. M. Harris, Fond du Lac.

To Camp Sherman, Ohio, from Camp Crane, Lieut. E. A. Gatterdam, Wauwatosa.

To Fort Sheridan, Ill., from Camp Grant, Lieut. J. A. Heraty, Milwaukee.

To Liberty, Mo., William Jewell College, from Kansas City, Mo., Capt. W. E. Ground, Superior.

To Vancouver Barracks, Wash., as tuberculosis examiner, from Denver, Lieut. L. F. Ruschhaupt, Milwaukee.

To Walter Reed General Hospital, D. C., for instruction, from Fort Leavenworth, Capt. J. C. Elsom, Madison.

To Biltmore, N. C., from Camp Wadsworth, Capt. A. O. Sanders, Superior.

To Camp Custer, Mich., from Fort Oglethorpe, Capt. A. De Pierre, Green Bay.

To Camp Jackson, S. C., base hospital, from Camp Joseph E. Johnston, Capt. S. G. Pake, Hayward.

To Detroit, Mich., from Fort Oglethorpe, Capt. V. F. Marshall, Appleton.

To Fort Sheridan, Ill., from Fort Oglethorpe, Lieut. J. F. McNary, Milwaukee.

To Lakewood, N. J., from Camp Crane, Capt. P. A. Fox, Milwaukee; from Fort Oglethorpe, Capt. C. W. Giesen, Superior; Lieut. V. J. Jacobsohn, La Crosse.

To Mineola, N. Y., from Garden City, Capt. E. J. Rollefson, Superior.

To report by wire to the commanding general, Central Department, from Madison, Wis., Lieut. V. C. Jacobson, La Crosse; from Milwaukee, Capt. J. D. Madison, Milwaukee.

The following order has been revoked: To Rockefeller Institute, for instruction in the treatment of infected wounds., and on completion to Camp Wadsworth, S. C., base hospital, for instruction, from Fort Oglethorpe, Capt. R. W. Jones, Wausau.

To Camp Gordon, Ga., with the board examining the troops for cardiovascular diseases, from Fort Oglethorpe, Lieut. R. E. Fitzgerald, Cudahy.

To Camp Sherman, Ohio, base hospital, from Boston, Capt. J. W. Powers, Burlington.

To Camp Wheeler, Ga., base hospital, from Camp Crane, Lieut. O. E. Ishmael, Mount Horeb.

To Fort Sheridan, Ill., from Fort Oglethorpe, Lieut. P. C. Hodges, Madison.

To Fort Snelling, Minn., from Fort Oglethorpe, Lieut. W. G. Sexton, Marshfield.

To West Point, Miss., Payne Field, as flight surgeon, from Mineola, Major C. W. Andrews, Waupaca.

To Camp Jackson, S. C., from Camp Wheeler, Major M. W. Hall, Mondovi.

To Chicago, Ill., from Camp Wheeler, Lieut. B. O. Bendixen, Kewaskum.

To Hoboken, N. J., from Camp Crane, Capt. W. P. Forkin, Chilton.

To Lakewood, N. J., from Fort Oglethorpe, Lieut. B. F. Koch, Wauwatosa.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to his proper station, from Camp Custer, Lieut. H. F. Berge, Eau Claire.

To Washington, D. C., St. Elizabeth's Hospital, from Camp Crane, Lieut. W. P. Miller, Milwaukee.

The following order has been revoked: To Fort Des Moines, Iowa, from Fort Riley, Capt. W. A. Ladwig, Wausau.

Avicenna hath it that no thing is more inimical to the innate heat and the heart than a great stench, for that by it the vital spirit is drawn from the heart, suddenly.

—Avicenna, Canones.

ABSTACTS

Coding Physical Examinations in the Amy. John P. Sharp (Niagara Falls, N. Y.), Washington, D. C. (*Journal A. M. A.*, Sept. 14, 1918), describes the method used by the Surgeon-General of the Army in recording the physical examination results of drafted men. The labor required is immense, but has been largely reduced by the system employed. After the war, when the work is finished, it will be of the greatest value. Any local board will be able to identify the men accepted or rejected, the names of individuals and causes of the rejection. When the reconstruction takes place it will not only aid in making over the disabled in the war but give useful data as to those rejected as physically unfit. At present the occupation of the drafted man is not included in the coding, but it will be done in the near future, so that statistics of the bearing of his occupation on his rejection will be available. The details are too elaborate for abstract. The article gives the diseases or defects which are considered as cause for rejection. A card system is used with numbers specially designed for the purpose giving the data for rejection by the numbers punched. Electric sorting machines are used.

Dysentery. G. B. Lawson, Roanoke, Va. (*Journal A. M. A.*, Sept. 28, 1918) recommends the rectal use of ipecac in amebic dysentery. His method of procedure is to put 60 or even 120 grains of powdered ipecac into about 24 ounces of water; this is kept hot for an hour, but not allowed to boil. After washing out the bowel with warm water, this whole preparation, without filtering, is given slowly by rectum to be retained as long as possible. If there is much pain and tenesmus, only a part of this can be given. In a few cases there was some discomfort and the treatment had to be slowed down. Formerly, he says, they used this method of treatment and at the same time gave salol-coated ipecac pills. Later on emetin (alkaloid) came into use and was used hypodermically with the ipecac by rectum. In two cases reported, the rectal treatment alone was used. Lawson believes that the hypodermic emetin treatment can be greatly aided by also giving ipecac by rectum. It certainly seems preferable to apply a treatment locally, rather than have it traverse the whole alimentary canal before reaching the seat of the disease, or than to give it hypodermically when it will diffuse through all the tissues of the body. It has also the advantage that it can be used by the patient when away from his physician.

The Epidemic of Influenza. The epidemic of influenza now sweeping over the country—a part of the pandemic now covering the world—reported in this country first from seaports and naval stations, and later from many cities, including at least twenty-five Army camps, with the craze for weird nomenclature accompanying war conditions, has been labeled "Spanish influenza." This, however, should not cause any greater importance to be attached to it, nor arouse any greater fear, than would influenza without the new name. This epidemic is of

course modified as to its epidemiology by the fact that large numbers of the most healthful portion of our population have been segregated in military and naval camps. The condition presumably started in Spain and spread throughout the various armies. It has already practically disappeared from the Allied troops. A typical epidemic as it existed abroad is described in the paper by Hewlett and Alberty in this issue of the The Journal; a typical epidemic at a naval station is described also too early to discuss here the exact identity of the in- in this issue by Lieutenant Keegan. It is needless and fectious agent. Few physicians will attempt to treat the condition with any special reference to its bacteriologic cause. The course of the disease is similar to the condition which has always been called influenza, except that it seems in some cases more severe, that it shows an extraordinary degree of contagiousness and that it is complicated or followed, in perhaps as many as 5 per cent of cases, by a massive and rather fatal bronchopneumonia. In its great prevalence it recalls the epiootic of earlier years. In the epidemic at Chelsea, Mass., this pneumonia was found to be caused by the influenza bacillus, which was recovered from 82.6 per cent of the lungs at necropsy, and in 31.6 in pure culture, frequently mixed, however, with pneumococcus or streptococcus infections. This pneumonia was fatal in 33⅓ per cent of the persons attacked by it. Early reports of the epidemic at the Great Lakes Naval Training Station indicate a similar incidence of pneumonia and mortality. Medical authorities of the Army, the Navy and the Public Health Service are thoroughly alive to the condition, and are taking active measures to control it. These measures are based on our knowledge that the disease is transmitted from person to person by direct contact, or indirect contact through droplet infection, and that it is therefore to be controlled by isolation and prevention of the transmission of these discharges. Because of the tendency to the development of the secondary bronchopneumonia, patients should be treated in well-ventilated, warm rooms with special consideration for the possibility of this serious complication.—*Jour. A. M. A.*, Sept. 28, 1918.

Albumin Test. U. P. Stewart (New York), Camp Gordon, Atlanta, Ga. (*Journal A. M. A.*, Sept. 28, 1918), describes a contact test for albumin in the urine with a mixture of picric acid, wet, magnesium sulphate, citric acid and distilled water as reagents. Picric acid is an excellent protein preciptant, but for detecting albumin in urine it must be used in a concentration that will not give false positive reactions. The proportion used in the formula of 10 gm. of picric acid, wet, with 400 gm. of magnesium sulphate, 20 gm. of citric acid, in 1,500 c.c. of distilled water was found to meet the requirements. The technic of its use is as follows: "An ordinary, heavy wall culture tube, 150 by 15 mm., and a piece of glass tubing 20 cm. long, with a diameter of 6 mm. and 1 mm. wall are procured. The reagent is poured onto the test tube to a depth of about 4 cm. It is advisable to use the centrifuged specimen, as the organized elements, in suspension, may give a false reaction, the same as with the heat test. The glass tube is introduced into the specimen to a depth of about 2 cm. The end of the tube is closed with the finger, as in using a pipet, and the tube is withdrawn and introduced into the reagent so that the level of the urine is slightly lower than that of the test solution. The finger is now removed and the urine and reagent will rise in the tube, giving a distinct zone of contact without diffusion. The tube may be removed to facilitate the reading, the finger being held between the light and the tube. In the presence of albumin a white ring will form, the intensity indicating the quantity. Faint traces, as found by the heat test, may be easily detected by this method. After each test the tube should be rinsed by being dipped in water. If the reagent in the test tube becomes cloudy, it should be discarded, as it is essential that the reagent and urine be clear. With a little experience, an estimation of the quantity of albumin can be as readily made as with the heat test." The method is claimed to be rapid and duplicates the results of the heat test very closely.

The Wire Cradle Splint. F. G. Nifong, Columbia, Mo. (*Journal A. M. A.*, Sept. 21, 1918), discusses the principles involved in treatment of fracture of the femur. He says only one clear idea is maintained throughout all texts, and that is the idea of fixation or immobility of the site of the fracture. To attain this idea other principles of equal or of greater importance have often been overlooked, such as suspension, extension and mobility, and also that of flexion of the limb in a position of physiologic rest. These principles may all vary in importance according to the age of the patient, the nature of the fracture, simple or compound, and other varying conditions. Fixation and extension should always be secured if possible, and flexion should not be ignored. Suspension and mobility are in many cases absolutely essential. Of all the various appliances, the author finds the Hodgen splint offers the most advantages, which he thus enumerates: "1. It immobilizes the site of the fracture most satisfactorily. 2. It gives any requisite degree of extension, with gravity counterextension. Extension is easily measured and controlled. Counterextension is not painful or injurious to the perineum and soft parts. 3. Abduction and adduction, with all the varying positions needed to secure bone apposition, are readily maintained. 4. Extension is within the splint (intraextension), leaving the entire limb and apparatus mobile and free. 5. Physiologic flexion is secured, thereby preventing hyperextension and muscle strain, with consequent bad functioning, and perhaps a paralysis. 6. It leaves the patient freely mobile, with the thigh swinging. It makes it possible for the patient to sit up and move about in bed, and therefore promotes comfort and good recovery. 7. An open wire cradle splint allows massage, inspection and the good care of the soft parts, which are great factors in getting functional recovery. 8. It is a splint easily modified to meet the indications for treatment of any fracture from the pelvis to the foot. 9. A modification is devised for transport service which is not yet excelled."

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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The Wisconsin Medical Journal, Official Publication

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Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
Brown-Kewaunee	A. O. Olmsted, Green Bay	E. G. Nadeau, Green Bay.
Calumet	W. C. Schmitz, School Hill	F. P. Knauf, Kiel.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	L. H. Prince, Madison	W. H. Sheldon, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	R. C. Smith, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	J. E. B. Ziegler, Eau Claire.
Fond du Lac	H. E. Twohig, Fond du Lac	F. M. McGauley, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	R. E. Flynn, La Crosse	Jens Rosholt, La Crosse.
La Fayette	J. C. Huhenthal, Belmont	H. O. Schockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	J. E. Meany, Manitowoc.
Marathon	W. E. Zilisch, Wausau	F. H. Frey, Wausau.
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Milwaukee	G. H. Fellman, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	A. R. Bell, Tomah	S. D. Beebe, Sparta.
Oconto	C. W. Stoelting, Oconto	Minnie Hopkins, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	E. R. Boyer, Rhinelander.
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Portage	D. N. Alcorn, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	G. C. Wichman, Rib Lake.
Racine	G. W. Nott, Racine	Susan Jones, Racine.
Richland	R. H. Delap, Richland Center	G. Benson, Richland Center.
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Shawano	J. B. Gordon, Shawano	W. H. Cantwell, Shawano.
Sheboygan	H. C. Reich, Sheboygan	T. J. Gunther, Sheboygan.
St. Croix	B. Kunny, Baldwin	O. H. Epley, New Richmond.
Trempealeau-Jackson-Buffalo	Wm. Belltz, Cochrane	C. F. Peterson, Independence.
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Walworth	M. D. Cottingham, Lake Geneva	E. Kinne, Elkhorn.
Washington	H. F. Weber, Newburg	A. H. Heldner, West Bend.
Waukesha	G. E. Peterson, Waukesha	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	J. W. Lockhart, Oshkosh	E. A. Hunt, Oshkosh.
Wood	Ed. Hougen, Grand Rapids	W. M. Rockle, Grand Rapids.

SOCIETY PROCEEDINGS

DANE COUNTY MEDICAL SOCIETY

The Dane County Medical Society held its annual meeting Tuesday evening, December 7th, at the Capitol Cafe. Influenza was the subject for a general discussion, led by Dr. C. A. Harper.

The following officers were elected for the coming year: Dr. W. H. Sheldon, president; Dr. W. D. Stoval, vice-president; Dr. H. P. Greeley, secretary; Drs. C. A. Harper, C. G. Dwight, and C. S. Sheldon, censors. The following delegates were elected: Drs. C. A. Harper and T. W. Tormey; alternates, Drs. S. R. Boyce and W. T. Lindsay.

FOND DU LAC COUNTY

The annual meeting of the Fond du Lac County Medical Society was held at the Irving Hotel the evening of December 30th. A committee was appointed to urge the establishment of an isolation hospital to be supported and maintained by the county and to be located on land to be donated by the Sisters of St. Agnes, adjacent to the St. Agnes Hospital.

The following officers were elected: President, Dr. C. W. Leonnard; vice-president, Dr. F. P. Marshal; secretary, Dr. D. N. Walters.

MARATHON COUNTY

The annual meeting of the Marathon County Medical Society was held at the Wausau Club the evening of December 6th. Dinner was served at seven P. M. Dr. S. M. B. Smith spoke on his medical work in France. The influenza situation was the subject of a general discussion.

MILWAUKEE MEDICAL SOCIETY

The regular meeting of the Milwaukee County Medical Society was held at the Hotel Wisconsin, Thursday evening, December 12th, and followed a dinner. Dr. Horace M. Brown addressed the Society on "Why Should the Medical Men Work for Insurance Companies for Nothing." He was followed by Mr. Lawrence Olwell, general counsel for the Old Line Life Insurance Company.

The Society elected Dr. G. J. Kaumheimer president; Dr. F. C. Studley, vice-president; Dr. Daniel Hopkinsin, secretary; Dr. A. R. F. Grob, treasurer; Dr. L. Boorse, censor. Drs. M. L. Henderson, W. Reineking, and J. A. Purtell were elected delegates to the next annual meeting of the State Medical Society.

RACINE COUNTY.

The annual meeting of the Racine County Medical Society was held December 19, 1918, at the Elks' Club Rooms, Racine, at 8:30 P. M. In the absence of the president, Dr. G. W. Nott, the meeting was called to order by the vice-president, Dr. J. G. Meachem. Reading of the minutes of the previous meetings were read and approved. Drs. Chresten Olson and Frank B. Marek, both of Racine, were duly elected members of the society. The following officers were elected for the coming year: president, Dr. J. G. Meachem; vice-president, Dr. F. C. Christensen; secretary, Dr. Susan Jones; delegate, Dr. J. S. Keech; alternate, Dr. W. P. Collins; censor, Dr. H. J. Brehm. Captain J. T. Corr, who has just returned from Camp Custer, Michigan, gave a most interesting account of his experiences in army work. Lieutenant F. C. Christensen has returned from Fort Leavensworth, Kansas. The attendance was fair.

SUSAN, JONES, *Secretary.*

ROCK COUNTY

The Rock County Medical Society held a dinner meeting at MacDonald's Restaurant, Janesville, the evening of December 3d, adjourning to Dr. Munn's office where the program was given. Drs. Ridge and Koenigsberg of the Great Lakes Training Station spoke on "Influenza and Its Treatment."

NEWS ITEMS AND PERSONALS.

Major Louis M. Warfield has been discharged from the service and is now associated in the practice of diagnosis and internal medicine with Dr. Louis F. Jermain, suite 1203, Majectic Building, Milwaukee.

Reports of the State Board of Health show a loss of 2260 Wisconsin lives in November as a result of the influenza epidemic.

Dr. and Mrs. F. R. Silverthorn of Berlin celebrated their 25th wedding anniversary, December 26th.

The annual report of the St. Nicholas Hospital, Sheboygan, shows a total of 2127 patients cared for during the past year.

Due to the influenza epidemic, the tenth annual meeting of the Wisconsin Anti-Tuberculosis Association which was scheduled to be held in Milwaukee, December 13 and 14 was indefinitely postponed.

H. H. Jacobs of the University Settlement, Milwaukee, has sailed for Italy with the Red Cross Commission on Tuberculosis to work with the civilian population.

Dr. H. E. Scott of Argyle was a victim of an automobile accident, November 25th. The car turned turtle, pinning him underneath. The doctor is again attending to his work.

The directors of the Madison General Hospital Association announce a gift of one thousand dollars received from Miss Sophia Klauber to permanently endow a room in memory of her brother.

Dr. George C. Ruhland, health commissioner of Milwaukee, has asked the Common Council for a bond issue of $150,000 for an addition to the South View Hospital.

Dr. G. F. Colter of Marinette who was recently injured has left the city in an effort to recuperate his health.

Otto F. Bradley, assistant secretary of the Wisconsin Anti-Tuberculosis Association, has resigned and accepted a position as secretary of the Minneapolis Tuberculosis Committee. Mr. Bradley has done splendid service in public health work in Wisconsin and the entire profession wishes him success in his new field. Mr. Theodore Werle will succeed him.

Mrs. Wm. Hopkinson of Milwaukee was severely injured in an automobile accident, December 28th.

Holy Family Hospital of Manitowoc has just installed a new X-ray equipment made possible by public subscription.

The evacuated army barracks at Clintonville have been utilized as an emergency hospital during the influenza epidemic.

Dr. Edward S. Evans of La Crosse was elected to the Executive Council of the Western Surgical Association at its twenty-eighth annual meeting in Chicago in December.

Dr. F. E. Tryon of Merrimac was injured in an automobile accident, December 23d.

Reverend P. B. Jenkins, pastor of the Emmanuel Presbyterian Church, Milwaukee, who has been with base hospital No. 22 as chaplain, returned home shortly before Christmas. Reverend Jenkins reports that when he left France it was expected that the hospital would return home about the last of January.

Dr. W. F. Krueger of North Milwaukee has located in Burlington.

Miss Anna J. Haswell, a member of the state board of nurses' examiners for several years, has been appointed superintendent of the Ashland General Hospital. Miss Frieda Gustafson of Park Falls will be her assistant. The general hospital building erected this season is nearly completed. A large number of rooms will be furnished by individuals and societies.

A committee has been appointed by Mayor Reinhart of Merrill to look over sites for the building of a public hospital.

The Trostel homestead, 808 Jackson Street, Milwaukee, has been turned over to the Society for the Care of the Sick, to be used as a hospital.

Dr. G. F. Hilton of Sturgeon Bay was badly burned about the face and hands on December 16th as a result of a gas explosion in his furnace.

Dr. W. J. Hommel of Whitewater has sold his home and practice to Dr. Unkrich of Monmouth, Illinois. Dr. Hommel plans on moving to California.

Dr. F. S. Wiley of Fond du Lac has been re-elected chief of staff of St. Agnes Hospital.

Sealed proposals are being received by the Lincoln county board for the erection of a hospital addition to the county home.

A. C. Clas, Milwaukee architect, has been chosen by the County Board committee to prepare the program for the architectural competition from which a plan is to be secured for the new county hospital.

A hospital association is being formed at Delavan to take over the Rice Sanatorium.

La Crosse county has doubled the capacity of its new tuberculosis sanatorium during the past year.

Dr. J. J. Rehorst of North Fond du Lac has been appointed surgeon at that village for the Soo line.

The Milwaukee Maternity Hospital has been firmly established by gifts amounting to $4,368 and a number of pledges.

The city of Sheboygan is considering the purchase of the old Born sanatorium for use as an emergency hospital.

The Medical Review of Reviews announces that it has just purchased the third oldest medical journal in America—the Buffalo Medical Journal—founded seventy-four years ago by Dr. Austin Flint, and published regularly ever since.

Plans have been started for a hospital council for Milwaukee to permit co-operation between hospitals and thus increase their efficiency. Through this medium it is hoped to ameliorate the present situation caused by the lack of hospital room. At a meeting in the office of Health Commissioner G. C. Ruhland representatives of hospitals decided to create a committee representing St. Mary's, Trinity, Hanover and Milwaukee hospitals and the health department to arrange organization of the council. Questions to be considered will be standardization of service, rates and a centralized budget. The following figures showing the population and hospital facilities of various cities were presented: Milwaukee, 436,535, fifteen hospitals, 1,325 beds; Buffalo, 468,558, twelve hospitals, 1,815 beds; Cleveland, 674,073, twenty hospitals, 2,250 beds; Cincinnati, 410,476, ten hospitals, 2,100 beds; Detroit, 571,784, thirteen hospitals, 2,700 beds; Minneapolis, 363,540, 2,406 beds; Omaha, 165,470, 1,416 beds The population figures are based on last 1910 census.

Greg A. Pavich, who, according to officials of the Kenosha Department of Health, is known as "The Austrian Doctor," was arraigned in the Municipal Court charged with practicing medicine without a certificate of registration from the state.

Millions of school children in the United States will be invited to become "health crusaders" for the Junior Red Cross and the National Tuberculosis association during the four months beginning Feb. 9.

Five counties report having public health nurses in November. These counties are Price, Barron, Sauk, La Crosse and Bayfield. In twenty other counties the effort of the women to induce the county authorities to appropriate funds for a nurse were without success. Kewaunee and Richland counties employed nurses in October, and Walworth county has money on hand and will hire a nurse as soon as a suitable one is secured.

In the current number of the Child Labor Bulletin, published in New York, Dr. George P. Barth, director of school hygiene in the Milwaukee schools, has an article on the question, "Why have health supervision of the working child?"

Plans for obtaining enactment of the state legislature of laws for the control of proprietary medicines, as a protection against self-treatment and for establishment of quarantine of men and women suffering from venereal diseases, were discussed on the first meeting of the Milwaukee committee co-operating in the government vice-crusade.

Dr. C. M. Echols was elected president of the medical staff of Emergency hospital at the annual meeting held at the hospital. Dr. William F. Wegge was named vice-president and Dr. Oscar Lotz secretary.

A total of $3,229 has been donated to the Madison General Hospital association in response to the Thanksgiving membership campaign recently inaugurated. Sums varying from one dollar to the gift of $1,000 from Miss Sophia Klauber have been received, according to a statement to the public signed by Sidney H. Stuart, campaign manager.

A fine of $200 was imposed by Judge F. A. Geiger on Max R. Zaegel, trading as M. R. Zaegel & Co., for alleged misbranding of Zaegel's Lung Balsam.

Further plans for the standardization of St. Agnes hospital, Fond du Lac, and arrangements for forming a staff, which is to consist of members of the profession there, who are members of the County Medical society, the State Medical society, and the American Medical association, were discussed at a meeting of the hospital staff held recently.

DEATHS

Lieutenant J. A. Powless of West DePere died in a base hospital in France on November sixth of wounds suffered while rendering first aid to soldiers in the advance lines on October 14. He was hit by a piece of shrapnel which entered his left lung. He was possibly the only commissioned Indian physician in the U. S. Army. Lieut. Powless was born on the Oneida Indian Reservation. He was a graduate of the Carlisle School and of the medical department of Marquette University, having graduated in medicine in 1904. He enlisted in the Medical Corps last March, received his training at Fort Riley and was commissioned as a first lieutenant. He was with the heroic "Lost Battalion" of the 77th Division, 308th Infantry, which was marooned on a hillside for seven days without food, surrounded by the Germans in the Argonne forest. He leaves a widow and two daughters, twenty and seventeen years of age. Mrs. Powless is a Skenandore, a remote descendant of the famous chief Skenandore.

Lieutenant Wm. T. Murphy of Waukesha, died in a military hospital at Grantham, England, on November second, of pneumonia. He was born in Milwaukee in 1880, was a graduate of Carroll College and of the medical department of Marquette University, class of 1904, and a former interne of the Milwaukee County Hospital. He is survived by a widow, three daughters, and one sister. Early in the war, Dr. Murphy offered his services to his country. He was commissioned a first lieutenant in the Medical Reserve Corps and sent to Fort Riley for training last winter. He was transferred to a Texas camp and later ordered to Newport News, Virginia, where he trained with an aero squadron. The middle of the summer he left with his unit for further training in England but the unit had not been placed in active service in France before the war closed. He was a member of the Waukesha County, Wisconsin State, and American Medical Associations.

Lieutenant Albert Devorak, a former resident of Casco, Wisconsin, died at Michael Reese Hospital, Chicago, Friday, December sixth. He graduated in 1917 and since graduation had been serving as an interne. He was commissioned a first lieutenant shortly before his death but had not been called to active service.

Dr. James Fitzgibbon of Racine died at his home on December fourth. He was born in Eden, Wisconsin, fifty-four years ago and located in Racine in 1895. He was a graduate of the Milwaukee College of Physicians and Surgeons, class of 1895, and was a brother of Dr. Wm. Fitzgibbon of Milwaukee and Dr. Gerritt Fitzgibbon of Chicago. Another physician brother, Dr. Thomas Fitzgibbon of Milwaukee, died about two years ago.

Dr. Albert Hayden of Shullsburg died at his home on December 7th of apoplexy. Dr. Hayden was sixty-eight years of age and was a graduate of the Washington University School of Medicine, St. Louis, class of 1876.

Mrs. Geo. M. Malkin, wife of Dr. Geo. M. Malkin, died at her home in Milwaukee, Saturday, November 30th.

Mrs. John P. Koehler, wife of Dr. John P. Koehler, deputy health commissioner of Milwaukee, died at her home in that city, Thursday, November 28th.

"Was the operation successful?"

"Completely so. It was the most brilliant demonstration of the operator's theory possible. Only one person appeared to be dissatisfied with the results."

"Who was that?"

"The patient's widow."—*Ex.*

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and
MRS. LOUISE BRAND, Milwaukee

INFLUENZA.

The meeting of the American Public Health Association in Chicago, held last month, brought together health officers and laboratory workers and others interested in health matters. The program for this meeting was made up largely of papers discussing the etiology, modes of transmission, and methods for the prevention of the present epidemic of influenza. A committee was appointed by the Association to prepare a pamphlet in which a working program against influenza would be outlined. The committee was to use the papers, committee reports, and discussions presented at the meeting in formulating these recommendations. The recommendations are at hand and are of sufficient importance to warrant the reprinting in this column of as much of it as space will allow.

INTRODUCTORY STATEMENT.

The present epidemic is the result of a disease of extreme communicability. So far as information available to the committee shows, the disease is limited to human beings.

The micro-organism or virus primarily responsible for this disease has not yet been identified. There is, however, no reason whatsoever for doubting that such an agency is responsible for it.

There is no known laboratory method by which an attack of influenza can be differentiated from an ordinary cold or bronchitis or other inflammation of the mucous membranes of the nose, pharynx, or throat.

There is no known laboratory method by which it can be determined when a person who has suffered from influenza ceases to be capable of transmitting the disease to others.

Laboratories are necessary agencies for the supervision and ultimate control of the disease. The research laboratory is necessary for the discovery of the causative micro-organism or virus, and for the discovery of some practicable method for the propagation of a specific vaccine and a curative serum. Clinical laboratories are necessary for the supervision and control of such vaccines and sera as may be used from time to time for the prevention of the disease and for therapeutic purposes, and for the information such laboratory can give to health officers and physicians as to such variations in the types of infective micro-organisms, as occur during the progress of an epidemic.

Deaths resulting from influenza are commonly due to pneumonias resulting from an invasion of the lungs by one or more forms of streptococci, or by one or more forms of pneumococci, or by the co-called influenza bacillus, or bacillus of Pfeiffer. This invasion is apparently secondary to the initial attack.

Evidence seems conclusive that the infective micro-organism or virus of influenza is given off from the nose and mouth of infected persons. It seems equally conclusive that it is taken in through the mouth or nose of the person who contracts the disease, and in no other way, except as a bare possibility through the eyes, by way of the conjunctivae or tear ducts.

PREVENTION.

If it be admitted that influenza is spread solely through discharges from the noses and throats of infected persons finding their way into the noses and throats of other persons susceptible to the disease, then no matter what the causative organism or virus may ultimately be determined to be, preventive action logically follows the principles named below and, therefore, it is not necessary to wait for the discovery of the specific micro-organism or virus before taking such action.

I. Break the channels of communication by which the infective agent passes from one person to another.

II. Render persons exposed to infection immune.

III. Increase the natural resistance of persons exposed to the disease, by augmented healthfulness.

I. *Breaking the channels of communication:*

(a) By preventing droplet infection. The evidence offered indicates that this is of prime importance.

(b) By sputum control. The evidence offered indicates that the danger here is due chiefly to contamination of the hands and common eating and drinking utensils.

(c) By supervision of food and drink. Evidence offered does not indicate much danger of infection through these channels.

Details and practical methods possible for the limitation of infection through droplets, sputum, and food and drink are discussed later under special preventive methods.

II. *Immunization and vaccines.*

In the present epidemic vaccines have been used to accomplish:

1. The prevention or mitigation of influenza per se.

2. The prevention or mitigation of complications recognized as due to the influenza bacillus or to various strains of streptococci and pneumococci.

In relation to the use of vaccines for the prevention of influenza, the evidence which has come to the attention of the committee as to the success or lack of success of the practice is contradictory and irreconcilable. In view of the fact that the causative organism is unknown, there is no scientific basis for the use of any particular vaccine against the primary disease. If used, any vaccine must be employed on the chance that it bears a relation to the unknown organism causing the disease.

The use of vaccines for the complicating infections rests on more logical grounds, and yet the committee has not sufficient evidence to indicate that they can be used with any confident assurance of success. In the use of these vaccines the patient should realize that the practise is still in a developmental stage.

The committee believes that when vaccines are used experimentally for the purpose of determining their preventive or curative value, the following conditions should be complied with:

1. The groups of vaccinated and unvaccinated persons should be the same in number.

2. The relative susceptibilities of the two groups should be equal, as measured by age and sex distribution, previous exposures to infection without development of influenza and a previous history as to recent attacks of the disease.

3. The degree of exposure in each group should be practically the same in duration and intensity.

4. The groups should be exposed concurrently during the same stage of the epidemic curve.

ADMINISTRATIVE PROCEDURES.

1. There should be laws against the use of common cups, and improperly washed glasses at soda fountains and other public drinking places, which laws should be enforced.

2. There should be proper ventilation laws, which laws should be enforced.

Since the disease is probably largely a group or crowd problem, the three following sub-heads are especially important.

3. *Closing.* Since the spread of influenza is recognized as due to the transmission of mouth and nasal discharges from persons infected with influenza, some of whom may be aware of their conditions but others unaware of it, to the mouths and noses of other persons, gatherings of all kinds must be looked upon as potential agencies for the transmission of the disease. The limitation of gatherings with respect to size and frequency, and the regulation of the conditions under which they may be held must be regarded, therefore, as an essential administrative procedure.

Non-essential gatherings should be prohibited. Necessary gatherings should be held under such conditions as will insure the greatest possible amount of floor space to each individual present, and a maximum of fresh air, and precautions should be taken to prevent unguarded sneezing, coughing, cheering, etc.

Where the necessary activities of the population, such as the performance of daily work and earning of a living, compel considerable crowding and contact, but little is gained by closing certain types of meeting places. If, on the other hand, the community can function without much of contact between individual members thereof, relatively much is gained by closing or preventing assemblages.

Schools. As to the closing of schools there are many questions to be considered.

(a) Theoretically, schools increase the number and degree of contacts between children. If the schools are closed, many of the contacts which the children will make are likely to be out of doors. Whether or not closing will decrease or increase contacts must be determined locally. Obviously, rural and urban conditions differ radically in this regard.

(b) Are the children in coming to and going

from school exposed to inclement weather or long rides in overcrowded cars?

(c) Is there an adequate nursing and inspection system in the schools?

(d) Is it likely that teachers, physicians and nurses can really identify and segregate the infected school child before it has an opportunity to make a number of contacts in halls, yards, rooms, etc.? We suggest that children suspected of having influenza and held in school buildings for inspection should be provided with and required to wear face masks.

(e) Will the closing of schools release personnel or facilities to aid in fighting the epidemic?

(f) If schools are kept open, will the absence of many teachers lower the educational standards?

(g) If a number of pupils stay at home because of illness or fear, will they not constitute a heavy drag upon their classes when they return?

(h) If schools are closed, is there likely to be an outbreak in any case when they are reopened?

4. *Masks.* The wearing of proper masks in a proper manner should be made compulsory in hospitals and for all who are directly exposed to infection. It should be made compulsory for barbers, dentists, etc. The evidence before the committee as to beneficial results consequent upon the enforced wearing of masks by the entire population at all times was contradictory, and it has not encouraged the committee to suggest the general adoption of the practise. Persons who desire to wear masks, however, in their own interests, should be instructed as to how to make and wear proper masks, and encouraged to do so.

5. *Isolation.* The isolation of patients suffering from influenza should be practised. In cases of unreasonable carelessness, it should be legally enforced most rigidly.

6. *Placarding.* In cases of unreasonable carelessness and disregard of the public interests placarding should be enforced.

7. *Hospitalization.* The theory of complete hospitalization is that, if all the sick were hospitalized the disease would be controlled. In certain somewhat small communities where hospitalization of all cases was promptly inaugurated the disease did come quickly under control. It must be recognized, however, that unless every infective person can be detected and identified as such and removed to the hospital before he has infected others, hospitalization can not be depended upon to eliminate the disease.

In general, home treatment is to be advocated where medical, nursing and other necessary facilities are adequate, and where home treatment is not directly contra-indicated by the danger of infecting others. The hospitalization in any case, mild or severe, should be undertaken only when facilities for home treatment are inadequate with respect to medical and nursing care or otherwise. The objection to routine hospitalization of mild cases lies in the fact that patients not already suffering from secondary infections may acquire them by exposure to hospital cases already so infected. The objection to the routine hospitalization of severe cases lies in the danger to the patient necessarily incident in the transfer from home to the hospital.

8. *Coughing and Sneezing.* Laws regulating coughing and sneezing seems to be desirable for educational and practical results.

9. *Terminal Disinfection.* Terminal disinfection for influenza has no advantage over cleaning, sunning and airing.

10. *Alcohol.* The use of alcohol serves no preventive purpose.

11. *Sprays and Gargles.* Sprays and gargles do not protect the nose and throat from infection, for the following reasons:

(a) So far as the knowledge of the committee extends, no germicide strong enough to destroy infective organisms can be applied to the nose and throat without at the same time injuring the mucous membranes.

(b) Irrigation of the nose and throat to accomplish the complete mechanical removal of the infective organism is impracticable.

(c) Their use tends to remove the protective mucus, to spread the infection and to increase the liability of actual entrance of the infective organisms.

(d) Their domestic use is liable to lead in families to a common employment of the same utensils.

(e) The futility of sprays and gargles has been demonstrated with respect to certain known organisms such as the diphtheria bacillus and the meningococcus.

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BOOK REVIEWS

THE SURGERY OF ORAL DISEASES AND MALFORMATIONS, THEIR DIAGNOSIS AND TREATMENT. George Van Ingen Brown, D. D. S., M. D., C. M., F. A. C. S., Milwaukee Wisconsin. Third edition. 734 pages, with 570 engravings and 20 plates, and a selected list of examination questions. Lea & Febiger, Philadelphia and New York. 1918. $7.00.

This book contains more than indicated by the title, as it is not only a complete treatise on oral diseases but also a work of reference, touching all medical interests in their oral relations. Thus the first chapter presents an excellent discourse on anaesthesia and anaesthetics, general and local, their methods of administration and their dangers, on hemorrhage and its treatment, and on shock. Other chapters deal with infection, fever, tetanus, tuberculosis, syphilis, etc., considering in detail diagnostic methods and treatment, diseases of the nervous system affecting the buccal region, nasal deformities and diseases in relation to the maxillae, diseases of the bone, glands, tumors, etc.

The special subjects are discussed in the sections on diseases of the mucous membrane of the mouth and on harelip, cleft palate, and defects of speech. These represent the chief part of the author's life work, and their discussion is based upon his extended experience in that line.

All important pathological conditions affecting, or influenced by, the buccal cavity and its immediate surroundings are entered upon, and the operative procedures are clearly described. A great portion of the illustrations are original and representations of the author's cases.

The most important change in this new edition is the chapter on war surgery, in which the author gathered representative ideas and methods published from the work of the hospitals of practically all the principal belligerent nations.

The subject matter is very well systematized and study greatly facilitated by the use of heavy type for the headings of the different paragraphs. From the broadness of conception in which the valuable work is written, it will be read with great interest and benefit by every physician.

C. ZIMMERMANN.

REVIEW OF "DISPENSARIES" BY DAVIS AND WARNER.

It is really a difficult thing for me to write a review of a book on a topic with which I am just becoming acquainted, for a profession of which I am not a member and which has so many traditions with which I am not familiar; traditions which this book assails more or less. Not until I began to write the review, did I come to appreciate this fact.

"Dispensaries," Their Management and Development, by Davis and Warner, published by the MacMillan Company, New York, 1918, should be of exceptional interest to the public minded physician. The trend in medicine is strongly away from the private, individual practice and is rapidly developing toward private and public dispensaries. The development has been very much accelerated by the war for, as Col. V. C. Vaughan has said: "Every one of the 30,000 medical men who are returning from army service has learned to know the value of group medicine."

As the authors point out in their preface: "Thousands of physicians are becoming accustomed to work in an organization instead of as individuals; hundreds are being trained in specialties of surgery, orthopedics, opthalmology and syphilology; new lines of medical research are being instituted and there will be new areas for the practical application of the results of research. Several million soldiers will receive systematic and adequate medical service and learn something of its work. The general public, and in particular, the employers, will understand as never before the economic value of health as an element in the productive efficiency of a people."

The authors very well show the public need of a more economical means for obtaining the resources of the medical profession, and they do not fail to point out the advantages for both the public and the profession in the dispensary system. In their broad experience as dispensary managers they have not overlooked dispensary abuses and devote some space to suggesting improvements in the existing systems.

The major portion of the book is in the nature of a handbook on the technical organization and efficient management of a dispensary. Chapters are devoted to buildings, records, follow-up systems, which will be suggestive to physicians in the conduct of their private offices on a modern efficiency basis.

THEODORE J. WERLE.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA. Third series. Vol. 39. This volume contains the papers read before the college from January, 1917, to December, 1917, inclusive, and is published in part by the income of the Francis Huston Wyeth fund. It is a pleasure to be able to pursue the deliberations of this society and read the excellent papers presented before it. The publication in permanent bound form makes a most valuable contribution to medical literature.

A PRAYER.

"O Father, while the Kings and Captains lift their swords to signal,
Turn thou to comfort hearts that bleed in little homes made bare.
Bend low to calm the children who are crying for their fathers,
And to soothe the lonely women who are weeping everywhere."

—Hodges.

ABSTRACTS

Gunshot Abdominal Wounds. J. R. Eastman, Indianapolis (*Journal A. M. A.*, Sept. 28, 1918), remarks on the advances that have been made in the treatment of abdominal gunshot wounds during this present war. Notwithstanding the fact that experience has modified the old views as to the advisability of delay in abdominal wounds, there still remains a sharp difference of opinion, notably in France, between those who trust to the development of symptoms for the diagnosis of penetration and perforation and those who prefer early laparotomy. There is not always an aperture of exit of the bullet to show its course. All missiles may ricochet, and Eastman has seen cases where, if it had followed a direct route, many vital organs would have been perforated and yet there was no serious injury. There are a few recognized rules to follow. The closer together the entrance and exit the less the chance of penetration, and Rochard declares that if a man does not cease to complain of abdominal pain a perforation is almost certain. Rochard also says that if a patient passes gas at the anus there is no perforation. All rules fail sometimes, excepting these three which show perforation: escape of bowel contents from the wound, protrusion of perforated intestine at the wound, and passing of the missile by the anus. The common signs of perforation are enumerated, such as pain, costal breathing, shock, abdominal rigidity, retraction of the testicle, etc., and the author adds the symptoms also of abdominal hemorrhage. Any of these may suffice to determine the propriety of operating. Among the deciding criteria are the nature of the missiles, whether smooth, deformed, etc. The question of transportation, the permanence or nonpermanence of the operative station, and the factor of time are to be taken into account. At the beginning of the war all surgeons were abstentionists, and Eastman gives statistics of operations by both methods which seen, if anything, more favorable for the interventionist. What may be called the internationally accepted treatment in nonoperative cases consists in rest in the recumbent position with shoulders raised and knees flexed. If the patient is moved before operation the Fowler position should be maintained during transport. Of course, abstention from food and care as to administration of water and anodynes are included. The more common injuries to the intra-abdominal organs, their symptoms and treatment are described at length, as are also those of combined injuries of the chest and abdomen, which are not uncommon. The article is full of interesting detail.

Myomas. A. E. Hertzler, Kansas City, Mo. (*Journal A. M. A.*, Sept. 28, 1918), discusses the cases of myoma in which, after a degenerative process, a hemorrhage has occurred which may end in several ways: absorption, continued fluidity, or clotting with vascularization and organization of the clot. The hemorrhage may result in perforation of the capsule covering the necrobiotic mass, and this may cause profound irritation of the peritoneum, and, lastly, a rapidly developing sarcoma may develop from the hemorrhagic tissue, and such cases form the main subject of the article. The variations that are observed in such cases as the last named are noted, and the author favors the idea that the sarcomatous cells are derived from the blood stream, which, he thinks, is supported by the genesis of sarcoma in other regions than the uterus. The disposition of the hemorrhagic myomas to form sarcoma finds a practical application in the fact that they are always objects of suspicion. Whenever any signs of hemorrhage or the changes that precede it are present the prognosis must be made with a certain reserve.

Parotitis in Pregnancy. W. P. Manton, Detroit (*Journal A. M. A.*, Sept. 28, 1918), reports a case of parotitis following induced abortion for pernicious vomiting in pregnancy in the thirteenth week. The disease continued thirty-three days with intense suffering, swelling of the neck glands and free suppuration. The case was clearly one of severe sepsis. The cause of the mumps in such cases has not been definitely discovered as applying to all cases. Symptomatic parotitis sometimes occurs as a grave complication in infectious fevers and is occasionally a sequel of other disorders. It may follow operations, and the existence of a distinct connection between venereal disease and the mumps has been demonstrated. The bacterial organism found in most reported cases, however is *Staphylococcic pyogenes-aureus*. There must be either a general or a local infection in any case of postsurgical or obstetric parotitis, either through the blood or directly through Stenson's duct. According to the nurse in the case reported, the patient had a very foul mouth before the attack of mumps, and Manton is inclined to think that the infection of the parotid gland was through the mouth instead of being of pelvic origin.

Well Baby Clinics. H. H. Yerington, San Francisco (*Journal A. M. A.*, Sept. 28, 1918), describes the plan of children's clinics used in the Stanford University Medical School, also that of the Associated Charities, which is somewhat different. Every woman delivered at the college hospital is asked to present herself and baby three weeks later, and the babies are brought for examination every week for the first three months, every two weeks from the third to the sixth month and every month from six months to one year. After that they are transferred to the children's clinic. The majority of mothers have acceded to this plan. Of course, the social service worker plays the leading part, and a card system is kept, postals being sent to those not attending the clinic, and if not answered the cases are followed up at their homes. The knowledge of home conditions is, moreover, a most important matter. The author gives a comparison of babies' weights which shows that the total loss is greater in San Francisco babies' averages in the beginning, but it is regained in about ten days, and at the end of the year the San Francisco infant's weight is 329 gm. heavier than that of any other baby previously recorded. The instructions as to infant feeding are given, and also the convalescent home and its experiences at Palo Alto are briefly described.

THE CIVILIAN WAR RATION. Never before, says Paul Roth, Battle Creek, Mich. (*Journal A. M. A.*, Sept. 21, 1918), has there been any war in which victory depended more on the support of the civilian. If food is to win the war, the civil population must be thoroughly impressed with the need of its co-operation. Nearly a year ago the Carnegie Institution of Washington suspended the bulk of its activities in the nutrition laboratory of Boston to undertake an exhaustive study of the effects on metabolism, physical and mental fitness and endurance, of reduction of the daily food allowance, which has been forced on several of the unfortunate European nations, and which may be felt in our own country, for the benefit of the Allied cause. A detailed report of the entire research will shortly appear from the pen of Dr. F. G. Benedict, director of the Nutrition Laboratory of Boston. His collaborators are Dr. W. R. Miles, H. M. Smith and Paul Roth. The publicity of such results should not be delayed, hence the present article. Briefly stated, the problem was to submit normal men to the reduction of the daily food allowance sufficient to cause a comparatively rapid loss of body weight, equivalent to approximately 10 per cent of the weight of the subject at the beginning of the testing period. Then the ration was to be increased and regulated to prevent any further loss of weight while retaining this reduced body weight for several weeks. This was to be done without materially interfering with the usual daily activities and duties of the subjects. Meanwhile, the subjects were to submit to numerous tests and observations relative to their metabolism, endurance and general physical and mental efficiency. They were fortunate to secure for this purpose the co-operation of more than twenty-five volunteers from the Y. M. C. A. College of Springfield, Mass. The subjects were grouped in three classes. Diet squad 1, of twelve subjects, who were kept under observation for four months with diet controlled as stated above. The control squad of twelve subjects, whose diet was not modified or controlled in any way, but who were subjected to several control tests for a period of three months. Diet squad 2, of twelve subjects, recruited almost entirely from the control squad, and who, for a period of three weeks, were placed on a practically reduced daily ration averaging about 1,400 calories net. The investigation included: a strict account of all the food served to the diet squad and determination of its calorific value. A collection of the urine of each subject of the diet squads in twenty-four hour periods, and frequent collections of the stools for several days each. Almost daily determinations of the basal metabolism, including estimation of pulse and respiration rate, total lung ventilation and alveolar carbon dioxid tension. Week-end trips, made alternately by each squad, to the nutrition laboratory in Boston for other tests. In Boston, spending of the night by the entire squad in a large respiration chamber constructed for the purpose of estimating the total metabolism of entire groups of subjects collectively. Also a series of observations made on the efficiency of each subject during muscular work. This was done with a treadmill, enclosed in a small respiration chamber. In addition, observations made on body weight, measurements of body surface, strength tests, oral, skin and rectal temperatures, blood tests, including hemoglobin and cell counts and blood pressure. Finally, the taking of photographs and motion pictures. The results are given in detail as regards the primary basal metabolism, and are summed up by Dr. Benedict. The general picture the men presented at the end of the tests was that of notable emaciation, especially in the face, but there was not any obvious reduction in stamina. Two of the men had chronic nasal disorders, one was operated on and the other should have been. During the study three men underwent ether narcosis for operations on nose, foot, and for hemorrhoids, and made rapid recoveries. One of the patients at his lowest weight went through a severe attack of typhoid fever with complete convalescence and recovery. The most noticeable complaint was that of a feeling of cold, but in general, notwithstanding the reduced metabolism, the whole period of lowered food intake had no untoward effect on the physical and mental activities. The control squad, having shown the absence of any seasonal variation in metabolism for about three months, was put on a very restricted ration of less than one-half the previous calory consumption. In all details the picture exhibited was the same as in the first squad, though the loss of weight was less and the phenomena quantitatively somewhat less emphasized. The alveolar carbon dioxid content of every subject remained constantly normal, and as regards muscular strength, there was only a very slight falling off in the strength tests with the hand dynamometer. The findings show that there should be no hesitancy in curtailing the civilian food ration in times of need. It should be clearly understood, however, that the diet of the growing child should never be voluntarily reduced. Diet reduction can safely include all food principles and many would be benefited by dropping occasionally or regularly one meal a day. The use of bran and liberal serving of coarse green or cooked vegetables is of value not only in satisfying the appetite, but avoiding constipation from reduction of bulk. The free use of fresh fruits will also be of inestimable value, and even water drinking before or during the meal will lessen the keen edge of the appetite. Eating between meals is an important source of waste and an enormous curtailment in the indulgence in sweets, candy and food luxuries is the patriot's duty.

CHRONIC ENDOCARDITIS. The facilities for examining and finding defects in apparently normal individuals have never been so great as at the present time, says L. M. Warfield (Milwaukee), Jefferson Barracks, Mo. (*Journal A. M. A.*, Sept. 21, 1918). Observations in the military hospitals and barracks have shown that many men who, so far as they know, are well, have certain defects, and while some of our ideas of the development of valvular heart disease have been abundantly confirmed, others have had to be modified. Most of the 43,427 men examined at Jefferson Barracks were under 31 years of age. About a quarter were mere boys, under 20, and the percentage of older men was slight. Warfield's attention

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are a usual indication of a weakness in the Anterior Transverse Arch. The finger points out the location of tenderness, pain and formation of callosities caused by depressed Metatarsal heads. The toes are dorsal flexed or cramped, shoes feel uncomfortable, the foot widens and spreads upper of shoe over the sole.

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was directed early in the work to the total absence of etiologic factors in cases of true mitral stenosis and aortic insufficiency. Mitral stenosis is a disease that is so definite as to make mistakes in diagnosis needless, but he has seen many men given their discharge on mistaken diagnosis of the condition. Cases reported as mitral stenosis were carefully examined, and no case was diagnosed as mitral stenosis that did not have definite presystolic thrill, presystolic rumbling ending in a definite, snappy first sound. The left ventricle in no case showed an enlargement. The author believes that they caught all the heart lesions occurring in the 43,427 men examined. A table is given of the heart lesions and the infections presumably causing them as ascertained from their histories. The total number of cases of heart disease was 157, including twenty-two of aortic insufficiency, twenty-nine of mitral stenosis, and the remainder of mitral insufficiency with or without hypertrophy of the left ventricle. In twelve cases of aortic insufficiency there was no history of infection, and in forty-two cases of mitral insufficiency and eight cases of mitral stenosis the same was true. Warfield is prepared to admit that some of the men denying history of disease may have had some infection in infancy, but this is doubtful, as almost every man can carry his history beyond the time he can remember. It is doubtful whether infections in infancy have as great a bearing on valvular disease as those occurring later in life. He thinks that it will be granted that the cases of mitral stenosis and aortic insufficiency were caused by definite changes in the valves leading to shortening, thickening and adhesions. With the cases grouped as mitral insufficiency, the same cannot be said. Possibly the cases with hypertrophy were true mitral lesions. There are, however, so many varieties of systolic murmurs heard at the apex, some of them purely functional, that the cause cannot be determined. The character of the murmur is not important as long as there is no hypertrophy of the left ventricle and there is normal response to exercise, with no history of symptoms. Syphilis, as shown in the table, plays but a small part as a cause of aortic insufficiency. This Warfield attributes to the youth of the men examined, as, according to his experience, syphilitic heart disease is a late manifestation and is found in most cases after 40 years of age. Even if there was no history of infections, it is not hard to believe that there may have been such, too mild to have been appreciated by the patient, like cases of walking typhoid, etc. Such cases are possibly the very mildest forms of acute endocarditis, running a symptomless course, and only detected by careful physical examination.

Diphtheria Carriers. The difficulties of controlling diphtheria in military hospitals are pointed out by F. R. Keefer (Washington, D. C.), S. A. Friedberg (Chicago), and J. D. Aronson (Philadelphia), Camp Doniphan, Fort Sill, Okla. (*Journal A. M. A.*, Oct. 12, 1918). They classify carriers into primary carriers: A, transient; B, chronic, and secondary carriers. A primary carrier is one who has never had clinical diphtheria. In transient carriers the bacilli are present only temporarily. The chronic carrier is one in whom positive cultures are obtained for an indefinite period of time, and sometimes intermittently. It is only by means of cultures that carriers may be detected, and a single negative culture is of little value. The authors describe the system employed in making cultures, and the local foci in which the bacilli can be found. The treatment is nonoperative and operative, and the methods employed in each are detailed. The operations, such as removal of the tonsils, etc., are followed by much of the same reaction as in normal patients, but if very severe, may suggest the existence of clinical diphtheria. The results of the methods employed are shown by tables, and their conclusions in substance are as follows: While a single negative culture is only of relative value, the importance of nasal cultures are emphasized, as are also the tests for virulence in cultures from chronic carriers. There is probably some underlying pathologic condition in these cases. In the great majority of cases the carriers harbor the bacilli in the tonsils, a few carry the germs in the nose only, and a small group has the infection in both nose and tonsils. Conclusions as to the results of local treatment should be based on prolonged and careful bacteriologic study. Cultures should be taken just before treatment, or, if local treatment is being administered, this should be suspended for a number of days, before cultures are taken. The results of local treatment are dubious, as the organisms are situated deeply in the tissues. In persistent carriers in whom the focus of infection is the tonsil, enucleation is the only certain remedy. In the most persistent nasal carriers, chronic inflammatory or atrophic processes exist, and it is very difficult to say when the condition has cleared. There should be centralization of authority for control of diphtheria epidemics and diphtheria carriers, and laboratory supervision is essential for release of patients from quarantine. When diphtheria abounds, all patients received in clean wards should have had at least two negative cultures from both nose and throat. Improperly constructed face masks give a false sense of security. The whole hospital personnel should be given a Schick test, the toxin for which should be prepared fresh. Those giving a positive reaction should be immunized with toxin-antitoxin mixture. No diluted toxin should be used after twenty-four hours, and the undiluted toxin should be kept in the dark and in a refrigerator. Intermittent chronic carriers should be employed as attendants in diphtheria wards or in quarantine camps, but they should be separated from the general hospital personnel. At least three negative cultures at three-day intervals should be required for discharge of diphtheria patients. Chronic carriers should not be discharged until cultures taken over a long period of time are consistently negative. Three charts and two tables accompany the article.

If a woman eat of the testicles of young cocks at the time of her conception, then shall she be delivered of a male child, when her time is come. (Zimara.)

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ORIGINAL ARTICLES

HEALTH SUPERVISION OF WORKING CHILDREN.*

BY GEORGE P. BARTH, M. D.,
MILWAUKEE.

The official statement of the Provost Marshal General backed up by a statistical table, which appears in his report to the Secretary of War on the first draft under the Selective Service Act of 1917 may well give us food for thought as it is an official test of the nation's physical stamina.

The physical examinations given throughout the country to 2,500,000 young men to determine their fitness for service in the army resulted in the acceptance of 71% and the rejection of 29%, which may be considered a very good index of the general physical condition of our population, at least of the one sex and that at the most vigorous period of life. There is no reason to doubt that a similar examination of the other sex would give similar startling facts as other investigations show that the female is subject to physical defects to an even greater degree than the male. The report also shows that there is no real difference between the young men of the city and those of the country as in urban areas of the total persons physically examined 71.53% were accepted and 28.47% rejected, while in the rural areas 72.04% were accepted and 27.96% were rejected.

Such figures disclose an unmistakably widespread prevalence of physical disability among a class of our population which should be in its prime. Surely, if the physical condition of these applicants disqualified them for service with the United States forces such conditions would constitute a handicap to them in other lines of work also.

A similar examination of the records of 72,410 applicants for service in the U. S. Navy for 1914 shows that 76% were rejected. Of the total number of rejections, 14.97% were due to defective vision, 8.61% to defective teeth, 10.77% to flat foot, 7.48% to deformities, and 5.79% to heart affections. Study of the rejections from a group of applicants numbering 73,028 for the same service in 1915 showed practically the same causes and proportions as in 1914. It must be understood, however, that these applicants by no means represented the same element of our population as did the selective draft.

Medical Inspection of School Children has attained a place of considerable prominence in child welfare problems but there is a strange apathy manifest in extending to industrial children the same care as is extended to school children. In a recent questionnaire sent out by the U. S. to all the large cities of the country it was found that medical inspection of schools was in operation in every state in the union even though all states did not have medical inspection laws on their statute books. There are not many cities now that leave to the parents of school children the entire responsibility for the health of their children. A number of states follow this up by requiring children to be examined by a physician before a permit to work can be secured, but with the exception of New York state, after the child goes to work no medical authority is charged with the duty of ascertaining the effect of employment on his health, and even the New York law leaves much to be desired.

The following are the present state provisions for the issuance of labor permits:

Issuing Officer alone determines physical fitness. (5)	HAWAII.
COLORADO.	KANSAS.
DIST. COLUMBIA.	MONTANA.
OREGON.	NEVADA.
WEST VIRGINIA.	N. CAROLINA.
WISCONSIN.	PHILIPPINE IS.
	PORTO RICO.
No physical restrictions. (21)	S. CAROLINA.
MISSISSIPPI.	S. DAKOTA.
ALABAMA.	TENNESSEE.
ALASKA.	TEXAS.
ARKANSAS.	UTAH.
GEORGIA.	VERMONT.
	VIRGINIA.
	WASHINGTON.
	WYOMING.

*Read before the 72d Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 4, 1918.

Issuing Officer may call in physician in doubtful cases.

(11)

CONNECTICUT.
FLORIDA.
ILLINOIS.
INDIANA.
LOUISIANA.
MAINE.
MICHIGAN.
MISSOURI.
NEBRASKA.
N. DAKOTA.
OKLAHOMA.

Physician must determine physical fitness.

(14)

ARIZONA.
CALIFORNIA.
DELAWARE.
IOWA.
KENTUCKY.
MARYLAND.
MASSACHUSETTS.
MINNESOTA.
NEW HAMPSHIRE.
NEW JERSEY.
NEW YORK.
OHIO.
PENNSYLVANIA.
RHODE ISLAND.

Most child labor laws have protected the interests of the child as far as two important considerations are concerned, i. e., the age qualification and the educational qualification before issuing a labor permit, but the most important of all, the physical and mental qualifications of the child to enter the industrial field have been overlooked by practically all agencies responsible for making these laws.

Of the 88,444 children examined in the Milwaukee Public Schools since 1913 there were found physical defects serious enough to require correction in 10,851. The proportion in which these defects were found are as follows: Hypertrophied tonsils 22.57%; adenoids 1.73%; defective nasal breathing 3.03%; defective teeth 66.10%; defective vision 23.76%; defective hearing 0.476%; orthopoedic defects 1.2%; pulmonary disease 0.26%; heart disease 0.94%; nervous disease (not mental) 0.55%.

These percentages cannot be regarded as absolutely correct however as in the examination of the children at school no clothing is removed and the defects are so evident that they are easily manifest to the trained observer. They are sufficiently accurate however to show that a real economic problem exists among children.

A personal examination of 745 children who appeared before me for a physical examination for a working permit (in Milwaukee many school principals will not sign the application of a child for a working permit unless its physical condition is first determined by the school physician) resulted in the withholding of the permit in 205 cases pending the correction of the physical defect.

Of 30,244 children fourteen or fifteen years of age who applied for working employment certificates examined in New York City from Jan. 1st to Sept. 30th, 1915, the following were found with physical defects:

Defective nutrition	2.37%
Acute eye diseases	1.30%
Defective nasal breathing	2.90%
Hypertrophied tonsils	8.62%
Pulmonary disease	.17%
Deformities	.54%
Defective vision	15.10%
Defective hearing	.95%
Defective teeth	32.85%
Defective palate	.68%
Heart disease	1.16%
Nervous diseases	.28%

In 1916 in New York City there were 545 children refused employment certificates on account of malnutrition; 425 cases with cardiac defects, and only three cases of pulmonary tuberculosis. Temporary (or easily remediable) defects caused the refusal of certificates to 946 children. These defects included defective vision, hearing, teeth and greatly enlarged tonsils, and contagious skin disease.

Statistics on the effect of industrial life on the growth and development of children are sadly lacking but an investigation by the Maryland Bureau of Statistics and Information which issues the permits for Baltimore City, examined in one year 1,500 boys previously employed in factories and found 93 serious occupational defects.

Of 100 boys who averaged 15 years of age in Baltimore, who have been employed in factories for an average of two years each, it was found that their average height was nearly one-half inch lower than the standard for 15 years of 5 feet 1 inch; their weight was 92 and 52/100 pounds as against a normal average of 106¾ pounds and only 58% were of pubic age.

Of 800 bakers examined in N. Y. for the army and navy, 57% had some disease or defect; of a similar number of tailors the percentage was nearly 63%; of 203 printers and 1,600 food handlers, it was only a little below 70%. Of a group of 2,086 male garment workers practically 100% were affected by some disease or physical disability.

For such ailments as defective teeth, defective vision, diseased tonsils, rhinitis, spinal curvatures, and flat foot, numerous occupations show proportions ranging above 25%, sometimes above 50%.

To say that the existence of any such great amount of ill health and physical disability among the nation's industrial workers is a serious matter

is merely to state a truism. Even though these disabilities may not, at least in their earlier stages, cause extended absence from work, the tax thus imposed on efficiency must be a heavy one. Obviously, maximum efficiency cannot be obtained from a force of workers one-fourth of whom are suffering from such disabilities as defective vision, nasal disorders, and deformities, or whose health is being steadily sapped by tuberculosis, alcoholism, or venereal disease.

The National Conference on Industrial Diseases, held in Chicago in 1910, estimated that a total of 284,750,000 days were lost through sickness by the 33,500,000 men, women and children then engaged in gainful occupations in the United States, an average of 8½ days per worker.

SICKNESS SURVEYS.

Community	Survey made	Percentages Sick	Percentages Unable to work
Rochester, N. Y.....	Sept., 1915	2.31	1.92
Trenton, N. J.....	Oct., 1915	2.55	1.98
State of N. Ca.....	Apr., 1916	2.85	2.29
Boston, Mass.	July, 1916	1.96	1.80
Chelsea Neighborhood, N. Y. C.....	Apr., 1917	1.48	1.38
Cities in Penn. & W. Vir. (white and colored)..	Mar., 1917	1.96	1.85
Cities in Penn. (white).	Mar., 1917	1.75	1.65
Cities in W. Vir. (white)	Mar. 1917	3.30	3.11
Pittsburg (white)	Mar., 1917	1.62	1.55
Kansas City, Mo.....	Apr., 1917	2.52	2.39
Average all surveys.....		2.02	1.88

This shows that on the average 2.02% of the population studied were sick and that 1.88% were unable to work, the proportions varying considerably in different localities.

With respect to the duration of illness, the Rochester survey showed that 50% of those who were sick had been incapacitated a year or more; the Boston survey showed 41.2%; the surveys made in Pennsylvania cities, 24.7%. In Rochester 59.3% of individuals too sick to work were found to have been ill for more than 26 weeks; in Boston, 50.1%; in Pennsylvania, 28.9%; in North Carolina, 32.9%; in most other surveys, over 30%.

The foregoing figures cover the entire population studies. For 376,573 persons 15 years of age and over covered in these surveys, the average loss of time was 8.4 days per year, or 6.9 working days, based on 300 working days per year. Females showed on the average, a slightly higher rate of disability than males.

If the sickness rates disclosed by these surveys for persons 15 years of age and over hold for the industrial population of the entire country, the annual wage loss for 40,000,000 workers from sickness may be conservatively estimated at from $500,000,000 to $750,000,000.

In the course of a health survey made in one of the industrial centers of Massachusetts physical examination was made of 720 families. The total number of examinations was 1,682. Major affections were found in 1,329 cases, tuberculosis in 48, while complicating illnesses and defects were reported in 1,211 cases, making the total number of affections discovered in the 1,682 examinations no less than 2,588. Of this total number of affections 55% were held to be preventable. The preventable and doubtful groups together constituted 84% of the total number of defects, leaving only 16% in the definitely non-preventable group. (D. B. Armstrong.)

It becomes obvious then that some form of supervision of the health of growing and developing children should be instituted.

Wisconsin is in a splendid position to lead all states in the union in the proper care and supervision of its permit children and to obtain the data so important and so much desired of the effect of industrial life on the health and physique of the child.

With a law requiring every community of 5000 population to establish a continuation school and a permissive clause for those under 5000 and a compulsory attendance law for the continuation school, the state can ill afford not to take advantage of its opportunities in promoting the welfare of the growing boy and girl. This can be done by establishing an adequate health supervision system in these schools providing for a frequent and systematic examination of all children working under permit, i. e., from fourteen to eighteen years of age.

DISCUSSION.

First Vice-President: The discussion on the paper of Dr. Barth will be opened by Mr. H. R. Pestalozzi, the Supervisor of School Attendance, of Milwaukee.

Mr. H. R. Pestalozzi, Milwaukee: Mr. Chairman, Ladies and Gentlemen: The State of Wisconsin has on its statute books a law which gives the Industrial Commission the right to issue a working permit or refuse it. Under that law we could compel a physical examination of each child that desires to go to work. For some reason or other we have not been able to convince the Industrial Commission of the wisdom of doing so. But Dr.

Barth and myself have made an effort for the last three or four years, and we have finally arrived at this result: that the Industrial Commission assumes that the principal, before he signs the permit, has certified to his own satisfaction that the child is well. How impossible this condition is, is very easily seen, when we consider that we have in the city of Milwaukee 147 schools and 147 school principals, and it is just as hard to obtain uniformity of action from them as it is to obtain uniformity of diagnosis among doctors.

We requested only this, that on the application for the labor permit there should be the question and a line for reply as follows: "Is this child physically fit to work or not?" And if this question is answered in the negative that the Industrial Commission shall refuse to issue the permit.

My experience has been that the floater and the delinquent child in the city among the industrial workers is largely the neglected child; that the child was not receiving and did not receive proper parental care; and that the child was sent out at the age of 14 into some industry, and then forgotten. What we intend to do in the city, and what we could do in the whole state of Wisconsin, with your assistance, ladies and gentlemen, is this: provide that no child be permitted to work at a gainful occupation unless it is in the best physical condition that your science can put it; furthermore, much has been said about the fact that we are taking care of the children free of charge. Now allow me to tell you something. We insist that every parent shall carry the burden of its offspring; it is only in the case of the very poor, those who are unable to meet the doctor bill and meet the hospital bill that we step in and do what common humanity dictates to every human-feeling being. You have to do the work in any event, and if you do it in your private practice you cannot collect the bill; if you do it as a charity case you will not charge anything; therefore, you are not disappointed.

I have made a study of the working child in Milwaukee—and I am in a position to give the following facts. We have in the city of Milwaukee at this time about 12,000 working children between the ages of 14 and 17 years; their average wage is $1.50 a day at present or $280 per year, which I consider rather low. The earning capacity of the 12,000 children is $5,600,000. There is lost to these children each year, through sickness, about $600,000. To take care of these sick children is not only humanitarian, but it is also profitable, because the parents get more money in the way of wages, and much suffering and agony of the heart and mind is prevented in the families.

Much will be gained if each of you will agitate for health supervision of the school children in the community in which you practice and if you will express to the Industrial Commission your willingness to examine all children before a working permit is issued.

In the city of Milwaukee we have a complete system of health supervision of all schools, that in the public schools being conducted by the Hygiene Department with Dr. Barth as its director and in the parochial schools by the Health Department. The doctors are in each school every other day, and any child that applies for a working permit can be examined in that school within two days. If a physical defect is found in that child, then that child is referred back to the parents, with the order that they should consult the family physician. And if, as I said before, the family conditions are such that the family is not in a position to take care of the sick child, it then becomes necessary for you, ladies and gentlemen of the profession, to do a charitable work. But all we desire for common humanity, for the abolition of suffering among children, and in order to prevent floating and delinquency among child workers, and the consequent unnecessary loss of money, is that we have Hygiene Inspection in every school in the state of Wisconsin, and that no child be permitted to go to work unless it is in the best possible physical condition.

I thank you.

First Vice-President: The paper of Dr. Barth is now open for discussion, if there is anyone that wishes to discuss it, or to ask any questions in regard to it.

Dr. J. P. Koehler, Milwaukee: As a member of the Health Department of Milwaukee, I am interested in the Health Supervision of every individual, beginning, as I might say, with the pre-natal care of that individual, until he enters the grave, and in a great many instances we are interested in him even after he is in the grave.

As a director of medical inspection of parochial schools, I am especially interested, as is also Dr. Barth, in the health supervision of children in the schools, and children as soon as they leave school. Our statistics are about the same as those of Dr. Barth. The majority of the defects consist in defective teeth and defective vision, and we endeavor to have as many of those cases as is possible, corrected by giving free dental work to the indigent, and trying to get the social agencies to help them obtain glasses. But we find that even with all of our willingness to assist them, we will still have children leaving school, ready to go to work, with these defects uncorrected. So that it is very easy to infer that when a child cannot be made to have the necessary dental work done, or to have the eyes looked after while it is in school, when we have had medical inspection of the schools for the last ten years, that we will also have difficulty in having that work done after they leave school. If it were so easy to correct these defects, none of these children who are now ready to go to work would have any of such defects, because they have been under the direction of either the public school or the parochial school inspection, but there are many difficulties encountered in the carrying out of our plans to have these corrections made. The result is that it is hard to have the corrections made by the time the child is ready to go to work, and I have felt that it is wrong, in many cases, to deny a working permit because a child has defective teeth. I believe in the supervision of children after they leave school and go to work, as no one can help but do who is in the practice of medicine, and who is especially interested in public health work. We believe in the supervision of all working people in factories, and that is why we have 30 Sanitary Inspectors. We believe in the supervision of children and men and women all over, wherever they may work; but the advisability of denying a permit because a child has some

defect has long been a question in my mind. I have done it, but I have sometimes felt that no permit ought to be denied unless the home conditions are investigated, and unless the place of employment is investigated. No man has a right to examine a child and say, "you cannot go to work because you have two or three bad teeth," and simply deny that child a chance to increase the family income. Who knows but, by giving that child an opportunity to increase the family income it may get more to eat, and in that way inprove its condition of malnutrition; the child may get more income and have the necessary dental work done. So in a great many instances I believe the child is in a better position if allowed to go to work, under strict supervision, than if the permit is denied.

I agree with Dr. Barth in his statement that the continuation schools ought to be under medical supervision, and that the children attending continuation school ought to have medical attention, but when it comes to the simple proposition of denying them a permit to work, I doubt whether we are always doing justice to the children. We will all admit that manual labor, if it is not overdone, is really much more of a normal occupation for the growing child than is mental work. We will all have to agree that 40 children in one room 30 x 24 certainly are not in the most healthful surroundings, and it is a question whether they are more crowded in the factories than they are in the schools. So if a child is well enough to attend school, and we do not exclude it from school on account of bad teeth, or some other minor defects, I believe that the home conditions at least ought to be thoroughly investigated before that child is denied the permit to work; and I believe also that if it were possible to so change our social conditions that the father could earn sufficient to support the family in the way that he ought to support them, you would be absolutely justified in saying that no children can go to work under a certain age; but when it is absolutely necessary for some of these children to work in order to have enough to live on, I think we ought to consider the case and investigate it thoroughly before we deny a permit. I do believe that these children should be supervised and their surroundings investigated, to ascertain that they are working under the most sanitary conditions possible, and I believe a law should be passed permitting these children to work only short hours, say six hours a day; no doubt that would help them a good deal and give them a chance to play. But I am not convinced, and do not feel that manual labor is the worst thing a child can do. And I think that Dr. Barth has admitted that statistics showing that children working in factories are going to go downhill as soon as they begin work, are very hard to obtain. Our plan ought to be to supervise the places where the children work, and see that the children have good hygienic surroundings in the home, and by education see if we cannot have the defects corrected, and at the same time give the children a chance to make their living.

First Vice-President: Is there further discussion of this paper? If not, we will ask Dr. Barth to close the discussion.

Dr. G. P. Barth, Milwaukee: Mr. President and Gentlemen: Just a few words in closing. Under the New York plan the permit of a child suffering from a physical defect is held up and the child is given six months in which to have the defect corrected. If the defect has not been corrected by that time the permit is denied in New York City.

I have experienced but little difficulty in securing the correction of defects by holding up the permit. The parent usually accompanies the child when it reports for physical examination for a permit. The entire school record of the child applying is placed on my desk and consequently we know whether a recommendation has been made with reference to a physical defect and what the attitude of the parent toward correction was.

If dealing with an indigent patient the patient is immediately sent to the dental clinic operated in connection with the department of hygiene if the teeth require attention, or if eye-glasses are needed these are supplied from a special fund, or if operative procedure is indicated arrangements are made with some hospital. In the 205 permits which were held up but little difficulty was experienced in persuading the parents to secure correction of the defect or defects.

If the conditions in the family make it imperative that the child go to work at once, the child is asked to go to a doctor or dentist and bring me a statement in writing from the doctor or dentist that he is treating the case in which event the permit is recommended, but with the warning that the permit will be revoked if appointments for treatment are not kept.

Working in this way we have had little difficulty in providing the child with proper care. I thank you.

Mr. H. R. Pestalozzi, Milwaukee: If I may be permitted just a word? It is a well known fact to all of us who are working with the class of people that we have to deal with, that the greediness of the parents at times is so great that recommendation upon recommendation is made to remedy physical defects in the children while attending school, and nothing is done. We have no power to enforce attention and correction. That child goes on year after year with the same defect, until it is ready to go to work. And the only power, the only weapon we can swing against such parents is the refusal of the permit. Such refusal of the permit touches the pocket-book of the greedy parent, and when that parent sees that the permit is not forthcoming unless the child is properly taken care of, they see the light, and the child gets the benefit of the attention which it has needed for many years past. I am therefore absolutely in favor of the proposition that no permit be issued to any child suffering from any remedial defect, until such defect be corrected if that is possible.

As Dr. Barth has well said, when the parents see that they are going to lose a week or two weeks' wages, they get very busy at once, and we have found that within two or three days the child was put in the condition that we attempted to procure for two or three years. I am in favor that no child be permitted to go to work, nor a permit be issued, unless the child is put in the best physical condition that medical science can put it.

PLAN OF FEDERAL AND STATE GOVERNMENT FOR CONTROL OF VENEREAL DISEASE.*

BY C. A. HARPER, M. D.,
MADISON.

The War Department has made a careful study of venereal disease as it appears in the young men on their arrival to the various cantonment camps and also the development of this disease as a result of camp life from Sept., 1917 to May, 1918. The average number of cases of venereal disease in the national army was 128 per thousand soldiers, of the regular army—98 per thousand, and of the national guard—76 per thousand, making a general average for venereal disease of 102.3 per thousand. The highest rate for any one month was in Sept., 1917, when 312 per thousand of the national army were found afflicted with venereal disease. The lowest number of cases was in Jan., 1918—71 per thousand, which again increased in May of this year to 243 per thousand. The lowest rate for the national guard was 53 per thousand in the month of December, 1917, and the lowest rate for the regular army was 71 cases per thousand, in February, 1918. In other words, as a general average for the year herein classified, over ten per cent of the fighting strength of the army was found afflicted with venereal disease. It is further stated that the number of cases of venereal disease contracted by men after putting on the uniform is astonishingly small, while the amount of chronic venereal disease brought to the army from civil life is a serious burden, and the army experience with venereal disease contradicts the popular impression that the boys and young men are under such influence and protection at home that they are in little danger of being exposed to that dreaded malady, but that in the army they are exposed to extreme temptation and are most certain to succumb.

In fairness, however, to the civilian population, it is pointed out that the disease brought into the army is the accumulated uncured disease of the newly enlisted men, but of these cases some of them are of years' standing. It is difficult to make an accurate estimate of the amount of venereal disease which would have been contracted if the soldiers had remained civilians, but the contrast between the old and new cases is so great that it seems safe to conclude that in civil life the men would have contracted much more venereal disease.

It is furthermore shown in addition to the comparison herein made that the Provost Marshal-General to the Secretary of War in a report showed that in the first draft 4.27 per cent of the rejections in a group of 10,000 men were due to venereal diseases. Of course, these rejected men never reached the army cantonments and, therefore, do not come in the previous classification wherein the average for a year was 102.3. These facts as they have gradually become known to the War Department of necessity arouse intense interest as to the serious dangers to military efficiency resulting from venereal disease infection, and, therefore, has caused the Federal Government, as well as the State government to become aroused to a condition which is lowering the efficiency of our citizenship and materially interfering with the active prosecution of the war.

As a matter of comparison with a few of the communicable diseases it may be shown that there were 102.3, or, including those rejected by the first draft, 106.57 cases of venereal diseases to a thousand soldiers, while of measles there were 80.4, of pneumonia 23.11, of scarlet fever 5.8, of typhoid and paratyphoid .23 per thousand soldiers under the draft.

With this alarming condition confronting the forces of the United States, Congress passed an act, approved July 9th, appropriating "$1,000,000 to be distributed to the States for the use of their respective boards or departments of health in the prevention, control, and treatment of venereal diseases, this sum to be allotted to each State, in accordance with the rules and regulations prescribed by the Secretary of the Treasury, in the proportion which its population bears to the population of the continental United States, according to the last preceding United States census."

In order to obtain its allotment each state is expected to adopt certain rules and regulations in conformity with the suggestions approved by the Surgeon General of the army, navy, and United States Public Health Service for the prevention of venereal diseases, and in expending the sum allotted a State certain rules and regulations to be promulgated by the Federal Government are to be followed as nearly as possible in the following manner:

*Read before the 72d Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 4, 1918.

1. For treatment of infected persons in hospitals, clinics, and other institutions, including arsphenamine and other drugs, 50 per cent of the allotment, 12,500.

2. In carrying out educational measures, 20 per cent, 5,000.

3. In carrying out repressive measures, 20 per cent, 5,000.

4. In general administration and other activities of venereal disease control work, 10 per cent, 2,500.

Of this allotment Wisconsin will receive about $25,375.70 and is expected to be deposited in the State Treasury for use within the next few days. In order to permit a state to receive its share of the Federal appropriation the state must have a law requiring the reporting of venereal diseases in accordance with State regulations approved by the United States Public Health Service. There must be a penalty imposed upon physicians or others required to report venereal infections and do not do so. Cases are to be investigated, so far as practicable, to discover and control sources of infection. The spread of venereal diseases should be declared unlawful. Provision is to be made for control of infected persons that do not co-operate in protecting others from infection. The travel of venerally infected persons within the State to be controlled by State boards of health by definite regulations that will conform in general to the interstate regulations to be established. Patients to be given printed circulars of instruction informing them of the necessity of measures to prevent the spread of infection and of the importance of continuing treatment. An officer to be selected by the State health authorities and to be approved and recommended for appointment by the Surgeon General of the Public Health Service. The salary of such officer will be paid by the State out of the funds made available by the allotment, except a nominal amount of $10 per month, which will be paid by the United States Public Health Service. The Federal government may permit a state to vary from its regulations generally outlined.

There are two points in which Wisconsin will probably need additional legislation. First, making the spread of venereal disease unlawful, and, secondly, prohibiting the travel of venereally afflicted persons within the State, although an effort is being made to stretch the present law to cover these two conditions.

The Department of Justice has issued instructions to all United States marshals that five days before completion of a sentence of a United States prisoner, who is suffering from venereal disease in the infections stage, he must notify the State Health Officer of the existence of such disease in the person about to be released from custody, and it will be necessary for the State Board of Health through one of its deputies to examine such person and if found afflicted with venereal disease in a communicable stage to continue to keep that person in confinement until the period of communicability is passed, or until other satisfactory arrangements can be made for the treatment of such person.

The Board of Health has endeavored to meet the conditions as they have developed and its rules and regulations for the prevention and control of venereal disease went into effect Oct. 1, 1918, and were published in the official State paper, the Evening Wisconsin, Friday, Sept. 20, 1918. These rules and regulations are gotten out in conformity to Chapter 235 of the Laws of 1917, and as amended by the special session of the legislature in 1918.

The law requires cases to be reported within forty-eight hours after the diagnosis is made, by number, name of the disease, conjugal condition, sex, age, color, stage of the disease, duration, occupation, if previously treated for such disease, by whom, and probable source of infection, and, furthermore, provides that when any physician treats a case of any venereal disease in its communicable form, such physician shall report to the State Board at once when such case is cured or ceases to be communicable, giving the record number of the case as in the original report. The period of communicability for gonorrhea shall extend over such time until at least two successive smears taken not less than 48 hours apart fail to show gonococci. The smears are to be collected in the female by the use of a small cotton swab and made on glass slides, the labia to be held well apart and the swab rubbed against the walls of the vagina. In every case in the female one smear should be made from the vagina, one from the cervix and one from the urethra.

In chronic, long standing cases in the male, it is necessary to massage the prostrate and express the

material from the urethral canal and spread smoothly over glass slides. Cases of syphilis should be regarded as communicable until all lesions of the skin or mucous membrane are completely healed, and a complete clinical examination shows the absence of any area from which infectious matter can be disseminated. The patient, however, when discharged as non-infectious, must be plainly advised that the disease is not cured, and although there is no infection at the time, he may subsequently become infectious to others through contact and the disease may probably be transmitted to his offspring until he is actually cured by a proper course of treatment carried on for a definite period. He should, therefore, be warned to remain under observation until such time as complete cure is effected.

When a physician is treating a case of venereal disease in its communicable form and the patient refuses or neglects to take treatments, or when the patient employs another physician, it shall be the duty of the first physician in attendance to report all the facts in the case, including the name and address of the subsequent physician, if known, to the State Board of Health immediately. Whenever any person afflicted with gonorrhea or syphilis ceases taking treatment before he or she has reached the stage of the disease where it is no longer communicable, or when any person has been informed by a licensed physician that such person is afflicted with gonorrhea or syphilis, and the person so afflicted refuses to take treatment, the physician shall forthwith notify the State Board of Health, giving the age, sex and conjugal condition of the person afflicted and the nature of the disease. The State Board of Health must without delay take such steps as shall be necessary to have such person committed to a county or state institution for treatment until such person has reached the stage of the disease where it is no longer communicable and the person so committed shall not be released from treatment until this stage of the disease is reached unless other provisions satisfactory to the State Board of Health are made for suitable treatment.

It is furthermore provided that whenever a case of venereal disease is found on premises where the case cannot be properly isolated or controlled, and when the infected person will not consent to be removed to a hospital or sanatorium, where he or she can be properly isolated and controlled during the period of infectiousness, or when such hospital treatment cannot be provided, the premises on which he or she shall continue to reside shall be placarded by the local health officer, and when so placarded shall be considered as a strict quarantine and all individuals will be strictly prohibited from entering or leaving the placarded premises, except with the written permission of the local health officer or the State health officer. The object of this is to have individuals afflicted with communicable diseases take proper treatment until the disease is no longer communicable. Many of such cases have already been reported.

Owing to the prevalence of venereal diseases amongst vagrants, prostitutes, keepers, inmates, employes and frequenters of houses of ill fame, prostitution and assignation, persons guilty of fornication, adultery, lewd and lascivious conduct, and illicit cohabitation, and all associates of all such persons, are to be considered and declared to be reasonably suspected of having syphilis, gonorrhea, or chancroid, and anyone arrested on any of these charges shall not be released on bail or otherwise discharged until examined and pronounced free from venereal disease.

The law also provides that with the approval of the Governor an extra cantonment area can be established around any military camp in the State of Wisconsin and special rules and regulations may be laid down concerning people entering this extra cantonment area.

This in general is the outline of the State Board of Health in its endeavor to form a working basis for the prevention and control of venereal disease in accordance with the principles laid down by the United States Public Health Service. The State Board of Control will endeavor to make provision in some of the State institutions for the handling of the certain classes of cases of venereally infected individuals, individuals, so-to-speak, having no visible means of support and who are indifferent or refuse to carry out proper treatment and follow certain instructions laid down to them by the attending physician. Also the law makes it imperative upon county institutions, when the necessity arises, to provide certain provisions for handling the venereally infected individuals who may be committed through court proecdure. The judge of any court of record may commit a venereally infected individual who disobeys the rules and regulations laid down. The complaints, however, to

the judge of such court are to be made by the state health officer or any one of the deputy state health officers, and the period of commitment to such institutions shall not extend beyond the time when the disease is no longer communicable, or beyond the time when other provisions satisfactory to the State Board of Health are made for suitable treatment after commitment to a state or county institution the certificate of the State Health Officer or the deputy state health officer making the complaint being prima facie evidence of either of such facts. Medical treatment shall be furnished without charge to such person, but the cost of maintenance shall be borne by such persin, if not indigent. Should the individual be indigent, the cost shall be paid by the county wherein such person was a legal resident at the time of commitment. If an individual in Wisconsin is found infected with venereal disease in the communicable stage and has no legal residence in any county in this state at the time of commitment, the expense for treatment shall be borne by the State.

One of the main objects of the Federal government and the health authorities of the various states is to put venereal disease in the list with other serious communicable diseases and to handle the situation accordingly.

Placards are either posted or are being posted in all the public places in the State of Wisconsin, calling attention to these serious maladies and briefly showing the dangers resulting from contractions of such diseases. Pamphlets of information are to be distributed upon request, free to any and all citizens of the State who may desire them. One pamphlet is labeled "Set A and C for Young Men and Boys," another "Set B, D and F for Public Officers, Parents and Educators," and a third pamphlet is in the hands of the printer, known as "Set E for Girls and Young Women," and a fourth pamphlet will shortly be in the hands of every physician in the State that he may give them to his patients who are afflicted with one or the other of these serious ailments. This pamphlet will deal in the main with precautionary measures to be used by the infected individual in order to prevent him from infecting other parts of his body and also prevent him from infecting those who may come in more or less immediate contact with him. The educational propaganda to be carried on will be in the form of leaflets and lectures, and the Federal government is now outlining this general method of procedure in order to have the educational program similar in each state of the United States.

We have done considerable publicity work through the newspapers of the State, calling attention to the seriousness of diseases of this character purely from a health standpoint, believing that when the facts are fully known, the vast majority of individuals will protect themselves from contracting the disease and the number of cases will be very materially lessened. The editors of the newspapers of the State of Wisconsin are to be congratulated upon their willingness to publish active articles upon venereal disease, as well as articles pertaining to other conditions affecting the health of our people, and this is as it should be. Only a short time ago I heard a health officer of one of the oldest and most important states in the Union make the remark that when he endeavored to get general publicity upon the subject of venereal disease practically every newspaper in his state refused to print his articles because it contained the name "venereal disease." These editors felt that it was something not to be mentioned in the newspapers. This ignorance has gone on so long that almost a calamity has overtaken the citizenship of this country, and the tenderfoot and the timid who heretofore have bitterly opposed the mentioning of these serious maladies to the young men and young women of this country are now lessening in number and when they dare raise their voice against such general publicity it falls upon deaf ears.

The element of quarantine of venereal disease will probably only be required in a small number of cases. A large number of cases of necessity, particularly of the indigent, will have to be taken care of in the state or county institutions.

The State Board of Health desires the hearty co-operation in the campaign against venereal disease of every physician in the state and appreciates the co-operation extended to it along all other lines. In return the State Board and the Federal government will endeavor to assist the physicians to the fullest extent possible in their handling of venereally infected patients. The state laboratory of hygiene at Madison, and the various state branch and co-operative laboratories will make microscopical examinations for the diagnosis of gonorrhea for any licensed physician in the state, without charge. The psychiatric institute at Men-

dota will make the necessary examinations of blood or secretions for the diagnosis of syphilis, without charge. It is to be hoped, therefore, that increased activities will be developed on the part of the medical profession at the present time as a war measure, and in the future as a protection to our citizenship as far as the question of venereal disease confronts us. Knowing the facts as they exist, no medical man can fail to do his best to prevent and control the communicable disease situation, unless he desires to be a member of the slacker colony.

In the past we have been handicapped for funds and also by the lack of a proper law to control these diseases. At the present time we believe that we have the necessary legal procedures to handle the situation, and by so doing not only improve the general citizenship of our state, but at the same time lessen the number of inmates in our charitable and penal institutions, many of whom are there as a result of the effects of syphilis and gonorrhea.

Within a few weeks a more or less complete detailed program will be formulated and presented for general distribution. The emergency of the situation permits a spade to be called a spade and the educational propaganda should certainly bring results.

In conclusion, therefore, syphilis, gonorrhea and chancroid are classed as communicable diseases, and made reportable on the part of the medical profession of the state as other dangerous communicable diseases are reported. The method of treatment in the vast majority of cases will be carried on by the physicians until a complete cure is brought about, and the administrative authorities will not be called upon to take action in any manner or form concerning these diseases. There are, however, a considerable number of cases of venereal disease in a semi-degenerate class of people who fail to appreciate the seriousness of their maladies and as such the arm of the law must come in and compel proper treatment and proper self control until the disease is no longer communicable.

DISCUSSION.

First Vice-President: The paper of Dr. Harper is now open for general discussion.

Dr. C. F. M. Schram, Beloit: At the present time there is a chance in the industrial field to do a whole lot of the publicity work which has just been mentioned by Dr. Harper. I am with the Fairbanks-Morse Company of Beloit, and we sent to Dr. Zinsser of the War Department to get 5,000 little pamphlets entitled "Your Job and Your Future." On Friday night of this week the foremen and superintendents of our shop, which employs about 3,500 men, are coming together for a talk, and we are going to outline what the War Department is trying to do in the venereal field. The men who are working in the industrial field come across an enormous number of cases that can be sent to the family physician; in other words, we can help out in a great big way in this publicity campaign on the education proposition. I have also a number of these larger placards which I have posted around the shop at the present time, and we are heart and soul behind this movement. I think it is a grand, great big proposition, and if we take hold of it, and we take hold of it strongly especially among the men in the industrial field where one has such an opportunity because of the large numbers of men who are there together, and they come to you for advice simply because they are not paying you for the advice. They know that I am not going to treat them, that I am going to send them to the family physician, and therefore, it is a frank open conversation that I have with them. I think we are going to be able to accomplish much in this way.

I would ask if I could meet the Industrial Surgeons, those on part time and those on full time, at the Wisconsin Hotel at 8 o'clock this evening, in room 137. Every man and woman interested in Industrial Surgery please be there.

First Vice-President: Is there any further discussion on this paper by Dr. Harper?

Dr. George C. Ruhland, Milwaukee: Mr. President, Ladies and Gentlemen of this Conference. I believe that the presentation of this paper by Dr. Harper is one of the most important that comes before this meeting. I think the nation as a whole has no greater and more serious problem than that of the venereal disease problem. Both as a problem under the present war conditions, as well as a social problem always, I think it should take first rank in importance. We have no less authority than Surgeon-General Gorgas, to the effect that this is one of the most serious questions which the Army, considering its efficiency, must solve. Surgeon-General Gorgas has said that, for the efficiency of the Army he would, if he were given the choice between the actual casualties of war and free from venereal disease, unhesitatingly choose freedom from venereal disease. Now that is putting the matter pretty strongly, and yet I think we in the Public Health Service, and you who are in actual medical practice, know that the venereal diseases are foremost among the devitalizing factors affecting nations. I believe the war has been fortunate to this extent, that it has brought up prominently the question of venereal disease. Now what are we going to do about it? I, least of any, would be willing to prognosticate just how far any plan is going to succeed. We know that popular prejudice is the biggest factor we must overcome in this matter. Obviously a national educational campaign, the

one which Dr. Harper has spoken of, one which will use the terms of gonorrhea and syphilis plainly, and get the public to understand them, and to understand that they are contagious diseases, is one big factor; but the other and rather troublesome factor is: what are you going to do after you have found these cases. If today we were to enforce the suggestion of the War Department, and would actually try to bring absolutely under control all the cases that we found, it would prove embarrassing, not only because of the enormous prevalence of these cases, but because of the physical impossibility to house them as we are told we should. But a beginning is to be made, and I think we have splendid opportunities if we will, for instance, take every individual who is convicted of vagrancy, and subject him or her to a physical examination to determine whether venereal disease exists, and if found, hold the patient until no longer infectious. I believe this can unquestionably be done under the plea of the existence of a dangerous communicable disease. Here in Milwaukee we have made the attempt, and have held patients, believing we might have a test case out of it, which might prove educational to the public. Unfortunately the case was not contested. The case that I have specifically in mind is now controlled, so far as the infective period of her infection is concerned, but we believe she is not mentally of the type that it is safe to allow at large. I believe the moment she goes out, she will repeat her past history. She is spending her time in state institutions, and will become infected again as soon as she is at liberty.

Now that suggests that something must be done to make disposition of patients that are immoral, or not responsible. I have a very definite suggestion in this connection on which I trust this Conference will, either now, or through its proper committee, take action. For some years past the state of Wisconsin has been spending money on the building of a home for delinquent women, the so-called Taycheedah Home, near Fond du Lac. There is grave danger that this institution will not be used for its intended purpose. The governor, undoubtedly from very good intentions, believes this institution should be used for the care of such soldiers who are returned disabled. That is undoubtedly a very good and laudible place, but I believe that it will miscarry, and that the policy of the Government and the public interest will better be served if this institution is reserved and maintained for the original purpose for which it was planned. I believe and hope, therefore, that this Society will go on record and express itself to the effect that this institution be used for the purpose for which it was originally intended. Such an expression from the medical profession, which, after all, represents eminently good authority, and one to which the Governor will undoubtedly give a willing ear will go far toward securing this institution for the purpose for which it was originally designed, and in that way make a beginning in taking care of these unfortunates who now go to the penal institutions for 60 or 90 days, and are then released and go out and again infect large numbers of people. Some institution must be provided to permanently house them.

Dr. A. R. Hollender, Mineral Point: I should like to ask Dr. Harper with reference to two matters that appealed to me while listening to his paper. There are a number of cases of venereal diseases that yearly come into the hands of two classes of people who have no right to treat these diseases. One class is the druggist. Several hundred cases of venereal diseases come into their hands and they find it very easy to prescribe or to dispense medicines for those so afflicted. Undoubtedly these cases will never enter the statistics because they are not reported. It seems to me that there ought to be some stringent legislation to prohibit the druggist from treating any kind of diseases, as they are violating the laws when so doing.

The other class is the case of the chronics who get into the hands of the so-called cults, chiropractors, naprapaths, osteopaths, etc. What means are to be taken to make this class report the diseases on the same basis as will be required of the medical profession?

Vice-President: Is there further discussion of this paper? If not, Dr. Harper, will you please answer the questions and close the discussion.

Dr. C. A. Harper, Madison: The questions which have just be asked, are very pertinent ones. Probably at the present time there would be some doubt whether we could compel the druggist to report the individual who buys a prescription, or is prescribed for by the drug clerk, supposedly to be used for one or the other of the venereal diseases. However, it will now be easy to obtain additional legislation. The Federal Government has appropriated a million dollars to be distributed to the various states, and it proposes to appropriate still more money; that is, it is hoped to be able to distribute it to the various states, but hereafter conditional that certain additional laws will be placed upon the statute books of the various states. And one of them is the prohibiting of the druggist from prescribing, and the prohibiting of the druggist from purchasing material advertised as curing venereal diseases. I think that subject will be covered at the next session of the Legislature. And it is also found that in many localities nearly 50 per cent of the cases of venereal disease go to the drug clerk for treatment, especially cases of the gonorrhea type; and of course the drug clerk fails, and the disease becomes chronic, and the cases become much more serious than the 50 per cent would have first manifested under proper treatment. The chronic case is a hard one to control. If it is infectious, and the authorities can get hold of the case, the individual can probably be so handled that he can be given instructions, no matter under whom he may be taking treatment, and he must follow these instructions; if he does not follow those instructions he can be taken before the court, either the Probate or County Judge of any county in the state of Wisconsin, and committed, and then, if necessary, paroled, providing he will follow the instructions. While we may not be able to cure that particular individual, or to get hold of him for proper treatment, yet we can prevent him from transmitting that disease largely to others.

There are points which, of course, are difficult to work out, and we have been holding off our rules and regulations on this matter at the instigation and suggestion of certain Federal authorities, because the Central Government has an Inter-Departmental Committee, which is going to take charge of the allotment of the money, and supervise the Federal work, and recommend to the states the lines of work which they are to follow.

I should like to say also, in conjunction with this, that the Federal Government, through the state boards of health, will furnish arsofenamine free to any physician of the state if he will administer it free to any patient under his control. So we shall shortly have a supply of that material on hand, to be administered to the indigent or semi-indigent individuals, if the physician will give the necessary service.

The suggestion made by Dr. Ruhland I think is an extremely wise one. There are two great big tremendous problems, among the other problems that we have in this state, one of tuberculosis, and the other of venereal disease. With relation of tuberculosis we have been able to talk about it, preach it from every angle, and the people are taking notice and living better and under better sanitary conditions, and we are going to eliminate that disease to a large extent. Venereal disease has been talked about under the bushes, not having come out because some ultra-refined individuals would create a very big disturbance. But the time is past for that attitude.

The question of the institution up at Fond du Lac is undoubtedly going to be used for a good cause, no matter which it is used for, but I believe with Dr. Ruhland, that it could be put to a more beneficial use, perhaps, in taking care of the venereally infected individuals than it would be if used for tubercular individuals, because the method of treatment, and the period of confinement is so different in the two cases, and tuberculosis can be handled so well in many similar and associated conditions, wherein venereal diseases could not be handled. I think that covers the field.

Naturally the success or failure largely of the program now to go into force will depend upon the spirit and the interest, and the hearty co-operation of the medical profession. By educating the people, and particularly by educating the patients to come to the medical profession that certain things should be done and must be done in order to remedy the existing evils that are now creeping unconsciously into society, much can be accomplished by the profession.

First Vice-President: Is it the wish of any of the members of the Society to take any action in regard to the suggestion made by Dr. Ruhland, as far as the institution at Fond du Lac is concerned? Would such action be of value, Dr. Harper?

Dr. Harper: I think it would be of great value, probably, if it were to come up in the form of a resolution, and be presented as a resolution, and go through in the regular form as a resolution. I know that we should like to see the attitude of the Medical Society on that question. And I furthermore believe that it would be of material assistance whether they obtained that institution or not, in obtaining some state institution in which these unfortunates can be housed and given proper care and treatment. I should like to see Dr. Ruhland get his suggestion up in the form of a formal resolution.

First Vice-President: The Chair is willing to entertain any resolution of that character, or is it the desire that a committee be appointed to draw up a resolution to be presented at the next meeting?

Dr. Harper: Yes.

First Vice-President: If a motion to that effect is made I will entertain the same.

Motion made that a committee of three be appointed to draw up a resolution to be sent to the Governor of the state, the resolution to be presented at the next general session, tomorrow afternoon.

Motion seconded.

Motion put and carried.

First Vice-President: The Chair will appoint on that committee, Dr. Ruhland, Dr. Redelings and Dr. Cunningham. They will kindly draw up such a resolution by tomorrow noon, and present the same at the general session tomorrow afternoon.

CARE FOR THE SOLDIER NEAR HIS HOME.

Keeping in close touch with the work of the military authorities and the American Red Cross and working hand in hand with them, the War Service Committee of the American Hospital Association has proved to be a valuable ally.

Among the very practical policies advocated by this committee, as stated in *The Modern Hospital*, are the following:

That existing hospital facilities be used, so far as possible, for military purposes. This would mean a great saving in construction and equipment of hospitals. It would likewise mean much to the invalided soldier in that it would be possible for him to be cared for in his own community where he could be within easy access of his friends and relatives.

That hospitals for returned soldiers be located in centers of population to insure the best medical, industrial, and transportation facilities.

That physicians at home be utilized for military service. Many of our best physicians and surgeons have been urged to remain at their posts to train new medical men and to care for the civilian population. It is only right that they be given an opportunity to share also in caring for the military population.

That volunteer hospital assistants be used to meet the shortage of nurses. This will permit the women of our country who have had some little training to, in a measure at least, release more nurses for active duty at home and abroad.

ELIMINATION OF DANGER IN THE TONSIL OPERATION AND END-RESULTS.*

BY FRANZ PFISTER, M. D.,
MILWAUKEE.

Every tonsil operation is a major operation. We have two kinds of major operations: the emergency operation and the operation of choice.

The tonsil and adenoid operation belong to the second class, that means that the physician has additional responsibility when he advises or urges this operation. Any severe accident that might occur in connection with it must be of grave consequence to him. Occasional reports of fatalities have been responsible for the fact that this operation is feared very much, which fact again adds to the physician's worries when he is compelled to reassure the patient or parent in order to have permission for the necessary operation.

Like all major operations, the tonsil—and adenoid—operation can never be guaranteed to be positively free from danger—(we read of deaths in extractions of a tooth)—but a great many things can be done to make it a comparatively safe surgical procedure.

The dangers lie in the anesthesia; in the asphyxiation through the aspiration of blood clots; in the immediate or the post-operative hemorrhage; in the pneumonia following operation, usually due to blood aspiration; and the so-called "status lymphaticus."

If we can improve our methods to such an extent, that we can say the danger as to life in a patient has been reduced to a minimum, we have robbed the operation of its terror.

One of the principle factors for a good and safe operation is that the operation should be done in a hospital and that the patient be left there at least 24 hours. It need not be emphasized that the home operation is not any more justified than an appendicitis operation at the house—that the dangers in the private house are multiplied. Only where hospital facilities are not available—and those conditions are not so frequent any more—should a house operation be considered. To be sure, we all have done them at the house and at the office, but so have we formerly done other capital operations; but not any more. We are continuously striving to eliminate the dangers of operations.

As to anaesthesia: *Local* anaesthesia as we use it in most of the adult patients is practically free from danger. The *general* anaesthesia for an operation in the mouth is the most difficult form of anaesthesia, because the anesthetist and operator are bound to interfere with each other and more or less bleeding adds to the difficulties. Therefore, if one can employ an operative method that allows the operation to be finished inside of say five minutes (tonsil and adenoids) actual operating time, the anesthetist can stop the anaesthesia at the time the operation begins. There may be other methods, but I know, that at least the "Sluder" operation, or some of its modifications, make it possible to finish the operation before the child wakes up. And in doing away with the anaesthesia during the operation, we have eliminated its chief danger. In this way we also, to the greatest extent, avoid the swallowing of the ether-saliva mixture and the danger of asphyxiation from a blood clot because the reflexes are reestablished early.

The patient is placed face down immediately after the operation and kept so afterwards when in bed. It may be said here, that the anaesthesia has unjustly been blamed for many a death, where the actual cause was asphyxiation.

We do not hear so much any more of bleeding to death after a tonsil operation, since it has been made a hospital operation, and since surgical methods are employed to control the hemorrhage.

There are three distinct periods when hemorrhage is apt to occur in a tonsil operation: *First,* during the operation. With improved methods, particularly the Sluder, we do not have much fear of striking a large blood vessel, so the bleeding is mostly from one or more small arteries, or just oozing. Prolonged sponge pressure will stop the bleeding in the greatest majority of cases. Tincture of iron or the compound tincture of benzoine may be advantageously used on the sponge. If not successful, artery forceps or a ligature will help and if all these things do not work out, the placing of a small sponge between the pillars (where the tonsil was) and sewing the pillars together with two silk stitches over the sponge—the sponge to be left in for 24 hours—will relieve all danger of bleeding.

These measures can be used in both—the local or general anaesthesia cases. The *second* period of hemorrhage is post-operative, starting within

*Read before the 72d Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 4, 1918.

12 hours of the operation and is usually brought about by wretching and by the restlessness of the patient. This is the most dangerous kind, because frequently not detected before the patient is well ex-sanguinated — the vomiting from the blood-filled stomach often being the first sign of alarm.

No time must be lost here with extemporising and waiting. If pressure with iron solution on a swab and ice don't give a quick and lasting relief, anaesthesia—which is well borne in the state of anemia—must be employed and surgical measures adapted as indicated before. One must not wait too long.

It is this class of bleeders for which hospital observation and care are so necessary.

The *third* period is between 8 to 10 days after the operation. Here a clot between the pillars has organized and become infected and caused bleeding when detaching. Any such clot must be rubbed off when found and the surface swabbed with a solution of tincture of iron.

All the sera and other solutions supposed to favor coagulation, may be employed with advantage, but the surgical methods used by the general surgeon elsewhere must and can be applied and relied on also in the tonsillar region.

If we can operate and finish our operation between the time that the patient arrives at deep surgical anaesthesia and the time he wakes up—which is usually five minutes and more; if we do not mutilate the throat; if we do the positive thing in case of hemorrhage, not depending on good luck; and if we do our operation in a well conducted hospital, we have robbed the operation of its terrors, we have made the operation as safe as any operation can be made.

Just a few words as to the end-results of the tonsil—and adenoid—operation. In regard to the local effect it may be said that whenever the operation has been done properly, there should usually be no untoward result after a few weeks and a clean surface may be expected where the pillars have been left intact. However, sometimes, in spite of a good operation, a severe inflammatory reaction and infection may cause scar formation, without causing much discomfort after a certain time has elapsed. There is nothing to the story that the voice suffers; on the contrary, very often it improves remarkably.

As far as the influence in the health of the individual is concerned, (most tonsils are removed in order to do away with focal infection), the experience in hundreds of thousands of cases all over the world, has proven, that the operation accomplishes a complete cure or at least a decided improvement from the original complaint in a very high percentage of cases. Of course, it cannot be expected to cure every ailment, principally because there are other sources of focal infection.

DISCUSSION.

Dr. E. H. Brooks, Appleton: Mr. Chairman and Gentlemen: I have enjoyed Dr. Pfister's paper very much. I want to say a few words relative to the technique of the tonsil operation. A year ago I took the matter up before the section of the Eye and Ear men of the State Society here in Milwaukee, but we had a very small attendance at that time, and I am very glad to present it as I see it to the larger number of doctors present here today.

I was in Philadelphia two years ago and saw the bloodless operation demonstrated with the La Force instrument. Prof. Skillern suggested that we had all been looking for a perfect operation for the tonsil, and he said, "Gentlemen, we now have it." We stood and watched him demonstrate some 16 or 17 tonsil cases, good, bad and indifferent. Some were old adhesions, and there were some that had been previously operated. And of the 16 or 17 cases that were operated there was practically no bleeding. The method, of course, is the same as the old Sluder method. You are all probably familiar with the instrument, which I have not with me, and which I wish I had. It is fitted with a clamp or hemostat, which squeezes down as the tonsil becomes inverted, and shuts off all circulation. By leaving this clamp on for two or three, or four or five minutes (as long as you choose), you have a complete atresia of the arteries and veins. The knife slides under the clamp, cuts the tonsil, is removed, and the clamp can be left on as long as you choose, even after the tonsil has been removed.

The great advantages of the operation, as I have found them after two years of experience—and I went home and began using the method at once, and have used practically no other method since—is first, the freedom from traumatism. With the force that you are obliged to put on the instrument. you would feel that you were getting more traumatism than you could possibly get in any other operation, but following our results and subsequent observation shows that there is hardly ever any of the discoloration of the throat, which is almost always found following the dissection operation.

Another great advantage is the freedom from deformity of the throat following the operation. In so many of the dissection operations it is almost impossible to keep from wounding the pillars, and a little niche is left at the top of the anterior pillar on one side or the other. In this Sluder method, with reasonable care, and

with the use of the La Force instrument, this is almost entirely done away with.

Another advantageous feature connected with this work, I believe, is the shutting off of the blood vessels, thus preventing the dangers of infection. In a great many instances we get operative cases following closely on acute inflammatory condition, and by clamping these vessels down tight, and taking the tonsil on the opposite or lingual side of the clamp, the prevention of infection is assured more than is the case in any other method, I am sure.

And last, but not least, is the hemorrhage proposition. Almost every one of these cases are done without hemorrhage. I have not a definite line on the exact number of cases that I have done in the last two years, but it is several hundred, and I have had just two cases in the two years that have bothered at all. One being a post-operative hemorrhage, 24 hours following, and I will state that at the time of operation there was absolutely no bleeding. The other case was one that occurred in my practice last week, the case of a young woman who was in a very much depleted condition, in whom I removed her tonsils and did a submucous operation at the same time. The tonsils were in a bad state of degeneration, and 12 hours after operation there was considerable hemorrhage. But I did not do anything to check the hemorrhage; did not suture; did not ligate; did not even mop the throat as it was not severe enough so that it was necessary to do any of these things.

I give you these points because I feel that in justice to yourselves, and in justice to your patients, no man can afford to not adopt the La Force instrument and the Sluder operation. I believe Dr. Skillern's assertion that the method comes as near to perfection in tonsil operation as we will probably ever experience.

As far as the anesthetic is concerned, the patient is put reasonably sound asleep. I do not feel that profound anesthesia is necessary. The tonsil is crowded through, and the clamp shut down, and while you are leaving the clamp on, if you wish to continue the anesthesia (if the patient becomes restless or begins moving), the anesthetist may turn the towel around the instrument, and continue the anesthetic in this manner, and the patient may be kept as profoundly asleep as is necessary. The technique, as previously stated, is the same as the Sluder. The instrument is passed below and behind the tonsil and followed up along the angle of the jaw, while the index or second finger of the opposite hand gently works the tonsil through, when the clamp is shut down. When the tonsil is engaged in the instrument or pressed through the instrument, the instrument stands at right angles to the mouth, and then the clamp is closed and locked, and left there as long as you choose. Both instruments may be used at the same time if desired; put one on each tonsil, and leave them on the desired time. In children I have been in the habit of leaving them from one-half to two minutes, and in adults generally about 4 minutes, and with that length of application I have had no hemorrhage of any consequence in the several hundred operations that I have done in the last two years.

PRESIDENT: Is there further discussion of this paper?

DR. S. G. HIGGINS, Milwaukee: I want to compliment Dr. Pfister on calling our attention to his technique, and to the use of the sponge, I would say, rather as an extreme measure. You will find that there is bleeding, and you can not control it by ligature. In that case it is quite permissible to use the sponge between the two pillars, and it is quite safe to do so. Recently I have been using only gauze in the nose and throat. This gauze is moistened by acetozone and oil. It is a liquid containing 1 per cent acetozone and ½ per cent chloratone. And if you use that the blood does not form a clot in which the gauze, which would otherwise adhere and be objected to by the patient in removing the gauze. I presume that everyone that has had any experience in this field could talk for hours and tell you his particular hobbies and his pride. A few of us who have had a good deal of experience along that line may be pardoned for stating some of the things which we think are essential. The fact that Dr. Pfister uses the Sluder technique and yet modifies it, and that Dr. Brooks uses the La Force instrument, and that I prefer the Beck instrument, leads one to believe that we are all somewhat individual in our work, and yet that the Sluder instrument, or any other one instrument is not perfect. You will probably find that you have to do a regular clean dissection in a great many of your tonsil cases, no matter what particular instrument is invented. One of the things that those of us who have specialized in this field have learned, is the necessity for illumination for all tonsil surgery, and there is a great deal of difference between having a proper light, either daylight, or better, artificial light, than to try to do this operation in some dark kitchen, as was done not too long ago, and as occasionally seems necessary now. I do not believe that the tonsil operation is ever emergency enough to require one to use methods which you know are not for the best interests of the patients. Therefore, I agree with Dr. Pfister that the operation is best performed either in a properly conducted office, or in a hospital. A good many of us prefer to ligate sufficient bleeding points rather than to use a sponge, and to ligate at the time of the operation. Personally I have not found it advantageous to the patient to do too much surgery on the nose and throat at one time. The patients will ask you to do a septectomy, a turbinate, and several things which may be necessary in the nose, and while you are at it, to remove the tonsil. It is quite enough to do the tonsil and attendants at one time, and take care of the other nasal work that may be necessary, at another time. As to the convenience of the patient and the comfort of the patient in after-treatment, I would say the first thing to do during the first 24 hours, and probably the first 48 hours, is to leave the patient alone. The mouth may be rinsed out with any antiseptic solution, but let the clot form, and do not pull it off, and do not have the patient gargle. Let them be comfortable. After the end of the third or fourth day you then have a muco-purulent sort of a miasm and clot in the wound. This is not a blood clot, but it is a tenacious mass, which certainly tastes bad

and smells bad, and is much better removed than allowed to remain. This cannot easily be removed by the patient gargling, but if you use a proper sized bulb syringe, or other form of syringe, and gently wash away all of this clot, you will have a clean surface, and it means much in regard to the comfort of the patient. You can afterwards apply anything you wish, glycerine and boric, or argurol, or silver, to the surface, so that the healing will be cleaner and smoother.

PRESIDENT: Is there anyone else who wishes to discuss this paper?

DR. A. E. RECTOR, Appleton: Nose and throat men may have been a little slow in developing some of the ideas that have been learned and followed by the much more experienced general surgeon, and among those is the handling of tissues to produce trauma. It must be admitted that the successful general surgeon of today is the man who goes in and does his work with the least possible manipulation of the tissues, and gets out again. In doing tonsillectomies you have the same surgical principles to follow. The less handling of the tissues, and the less there is of manipulation, the quicker you acquire what you are after, which is the end-results. And after an opportunity of two years' experience in following the Sluder method with the La Force instrument, I think we are safe in saying that there is less manipulation of the tissues, there is less reason to iritate the tissues afterwards, there is less reason to use sponges, there is practically no reason for ligatures, and there is practically no reason to sew a sponge in the throat, as the only hemorrhage you have in these cases is the case of a natural bleeder, and an occasionally large vessel, with that one vessel clamped off, or possibly ligated. I have not as yet seen one case that needed ligating, and we have had no laceration of the tissues, we have had no trauma, and we have had no use for sponges. Another great advantage in the Sluder operation with the La Force instrument is the doing of the adult cases under local anaesthesia.

Your patients have seen so many of these cases with more or less hemorrhage, that they themselves are always astonished that there is no blood. The instrument left clamped on under local anaesthesia from 1½ to 3 minutes leaves you a mouth that is perfectly free from blood. In a great majority of the cases you will not see as much as two drops of blood in the saliva that is excreted at the time, and you have no after formations of clot to be washed away. From the separation in the forcing through of your tonsils you have the little fibrous pinnacles formed and by the curling up of these with the excreted fibrin of the blood, a scab which is not like the scab exposed to the air, because it is moist; you have the white brane there, and you have your wall built up immediately with no clot of blood left, and with no chance for infection to occur; and I think that anybody that uses the Sluder method with the La Force instrument, and becomes acquainted with it, is not very likely to revert to other methods, as you have your pillars intact, you have no cicatricial tissue to transform the pharynx involved, and you have the natural voice and the natural conditions afterwards.

PRESIDENT: Is there further discussion of this paper?

DR. M. N. FEDERSPIEL, Milwaukee: I do not specialize in nose and throat work, my work is limited to the treatment of diseases and deformities of the mouth, jaws and face. I have had the opportunity to notice many patients who come to us for the relief of mouth breathing to have the dental arches expanded in order to give more space to the nasal channels. In some of these patients the arch relation is normal as well as the nasal channels. These patients give a history of having been operated upon for the removal of adenoids and tonsils. Yet in these very cases I have frequently discovered a predominance of adenoid tissue which probably never was removed. No doubt, that is why we find mouth breathers who have not been benefited after an operation. I believe this is largely due to faulty technique. I wish that Dr. Pfister had called attention to the pre-operative treatment. It is somewhat disgusting to know of specialists operating in hospitals for the removal of adenoids and tonsils in patients with unclean mouths. Time and again have I noticed patients being operated upon whose mouths were in a filthy condition containing diseased teeth with deposition of tartar and pus-pockets. Negligence in cleaning up this condition before operating must in all probability invite infection and secondary post-operative hemorrhages.

PRESIDENT: Is there further discussion of this paper? If not, we will ask Dr. Pfister to close the discussion.

DR. FRANZ PFISTER, Milwaukee: Mr. Chairman and Gentlemen: We are never too old to learn, and never too old to change to better methods, if we can be convinced that there is such a thing. And in speaking of results, and good results, due to the improvement in technique, I want to say that the longer we have operated, the better our technique becomes. I see the mistakes that I have made in the past, and I try to improve my work. I think I was perhaps the first one in this state to use the "Sluder" method. I heard Dr. Brooks' eulogy on the new variety of this operation last year, and have promised him to try it. I will repeat what I was trying to make particularly strong, and that is, that one can do a tonsil operation and an adenoid operation together, inside of 5 minutes in a child—and I am speaking of a child. If you can do that, you can dispense with the anesthesia during the operation; you can stop giving ether after the child is soundly asleep. And there is where the chief advantage in the method that I would advocate, lies. Dr. Higgins says, only as an extreme measure should a sponge be used. I have found that if you have a patient in the hospital, and the nurse notifies you of a post-operative hemorrhage, or maybe does not notify you in time, and you get there by hook or crook to find the patient just about alive, and as pale as a ghost, and no pulse, you have not much time to select the method. I find it is such a simple thing to pick up that posterior pillar and drop the sponge in the pocket thus formed, and put in two stitches. It does not cause any discomfort to amount to anything for the patient, unless the sponge is too large, and, as I have

said from the start, the wound looks beautiful the next day when the sponge is removed; there is no infection. Even in hospitals we have to figure that sometimes, and particularly now in war time, we cannot have the services of a house physician because most of our hospitals have no house physician. If you happen to live five or six miles, or some such distance away from the hospital, it feels mighty good to know that there is no possibility of hemorrhage, and there is none with the sponge. I do not see where the advantage of the stitch comes in. Sometimes the putting in of a stitch in the proper place is more difficult than putting in that little sponge. The one disadvantage in the sponge is that the next day you have to take those few silk stitches out, but as a rule that does not give much disturbance to the patient.

There should not be a clot in the tonsil fossa between the pillars. If there is a clot it should be rubbed away, and the bleeding should be stopped, because we know that the clot is the thing that is going to make the trouble afterwards, and is liable to produce late hemorrhage.

Dr. Rector is very enthusiastic about the new instrument. He says that there is no hemorrhage following the operation, but I think the abdominal surgeon does not trust the clamping of a bleeding surface absolutely; he wants some ligatures besides, and we have to follow similar surgical rules. Every Saturday morning we have a number of patients in our clinic; there are different men doing the work, and changing off, and if we have a hemorrhage later in the day, I have the house physician and the surgical nurse in the hospital trained so that they know what to do. They anesthetize the patient, lift up the posterior pillar, drop in the sponge, and put two silk stitches through both pillars, and then they know that there is no further trouble. It is not necessary to do it every time there is bleeding; other methods can be tried first. But if I operate on a man like myself, or at an age past middle life, I do not feel safe to leave him over night in the care of somebody that might not know what to do. I put the sponges in there right at the time of the operation, and the sponge does not bother the patient at all.

The point made by Dr. Federspiel in relation to preoperative treatment is very well taken, indeed. I very frequently tell the patient that comes for a tonsil operation, that he had better go first and have his teeth examined and attended to, and when he is through with that, and there is still some trouble with the tonsils, or they do not change any in the meantime, then we will take them out. I think the teeth are the source of the focal infection more than the tonsils. The tonsils are the receptacle; the nose and the teeth—the teeth in the first place, and the recesses around the teeth, are the manufacturing centers for the bacteria. The tonsil is mostly the place where they are received, developed and sent onward into the system. I believe that the manufacturing centers should be first cleaned out before the operation on the tonsils is done. I also feel the same as he does with reference to the amount of jewelry on the teeth, that the amount of jewelry in the patient's mouth is in indirect proportion to his general health.

HOW PENNSYLVANIA PLANS TO HELP ITS SOLDIERS, SAILORS, AND MARINES CRIPPLED IN WAR SERVICE.

At least one state intends to see that her crippled sons are not made objects of charity when the days of peace come. In the Bureau of Employment of the Pennsylvania Department of Labor and Industry, says *The Modern Hospital*, extensive card files recently installed, indicate where 42,111 soldiers, sailors, and marines, crippled or permanently disabled through war service, may find in Pennsylvania suitable employment despite their disabilities. More than half of the 42,111 employment openings, are in skilled tasks that may be performed by men having lost one or both legs, an arm, or who are handicapped by other disability. Places of employment range from steel mills to dairies, from silk mills to railroads, from cigar factories to paper mills, and from lumber camps to department stores. The various positions are classified by industry, locality, occupation, and by disability of workers to be employed so that disabled men may be placed with the least possible delay.

THE RED CROSS MAN.

By Jeanne Judson.

The Red Cross man was here today,
He seems to know some magic way
Of being everywhere;
In Paris when a chap is broke,
He passes out a Yankee smoke
And at the front, he's there.

He gives us something hot to drink,
He seems to want to make us think,
We're happy and at ease;
He keeps as busy as can be,
Just working for my mates and me,
His method sure does please.

And though he doesn't tote a gun,
We know he's with us everyone,
Till duty sets us free;
His wheeled canteen is far more fair
Than any lobster palace rare,
We drink his health in tea.

In a part of Aethyope the Hyene coupleth with the lyonesse, and between them is engendered a monster named a Crocute. Which is likenesse also counterfeiteth the speech of man. He never stirreth ye balles of hys eyes, but stareth continually without twinckelling.

—Caius Julius Solinus.

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ROCK SLEYSTER, M. D., Editor
Waupun

J. P. McMAHON, Managing Editor
141 Wisconsin Street, Milwaukee

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EDITORIALS

YOUR JOURNAL.

If you have a bit of news,
Send it in.
Or a joke that will amuse,
Send it in.
An incident that's true,
A bit of stuff that's new,
We want to hear from YOU—
Send it in!

RESOLUTIONS.

1. I will pay my 1919 dues *today*. It is a just obligation and one from which I receive much in return. My county society needs the money and I do not want to be dropped from its roll, nor do I want to be without THE JOURNAL or the Medical Defense protection afforded by my State Society.

2. I will add at least one new member to our society this month. Maybe my assistant, or my young associate, or my old medical neighbor is not a member and awaits an invitation. We need each other, and together, I am sure, we can accomplish much for the common good.

(Signed) EVERY MEMBER.

Jan. 1, 1919.

TO THE COUNCILORS AND COUNTY OFFICERS.

SEVEN HUNDRED AND EIGHTY-EIGHT Wisconsin physicians responded to the call of our country and entered the medical department of the U. S. Army and Navy. They have met every demand made upon them. They have made good. They are coming home now, one and two and three at a time.

When they left, we were living in a most intense and emotional time. We bade them goodbye with a firm hand-grasp and a promise that their home interests would be protected and their places kept for them. Now that the excitement and hysteria are over and we are returning to that old familiar "Safe and Sound" (?) state of mind, let us not forget! These promises can not be kept without a harmonious medical organization in each county of the state.

Because of the absence of these men and the enormous amount of work thrust upon the physicians remaining at home, many of our County Societies are in a seriously disorganized condition. Many have held no meetings during the past year. A few are even without officers to call a meeting, all officers having enlisted. This condition must not be allowed to continue. The work of reconstruction applies even to organized medicine in Wisconsin and our duty is plain.

At the January meeting of the Council, each Councilor was instructed to immediately get in touch with each county society in his district, to

see that meetings are called without delay, officers elected, dues collected, and a reconstruction program outlined. It is the duty of each Councilor and county officer to unselfishly give the necessary time now to put his house in order. When our absent brothers return, let it be to something that is worth while, something that can and will make good the promises made to them when they went out to work and fight for us. Let us demonstrate something of the team-work they have been accustomed to in army life and which they will demand on their return.

We shall hope and expect to have a good report from each of you. Write to us of conditions and tell us what you have done and what we can do to help. Get busy, today, and you will be happy in the knowledge of duty well done.

ROCK SLEYSTER, *Secretary.*

OCCUPATIONAL THERAPY.

EVERY one of the leading countries engaged in the great war has already made provision for the vocational re-education and placement of disabled soldiers and sailors. The consideration which moved England, Canada, France, Italy, Germany, and Austria to undertake this work has appealed with even greater force to the people of this country.

Such training is required to insure economic independence, to avoid vocational degeneration, to prevent exploitation, to conserve trade skill, to insure national rehabilitation, to adjust the supply of labor, to demand and to develop new vocational efficiency.

But aside from all of these reasons, the therapeutic value of properly directed labor has at last been recognized. The government has officially approved the value of occupational therapy for the disabled soldier and sailor but the state and profession have so far failed to apply in any general way the principle to the same conditions in civil life.

It is not the purpose of this editorial to define or elaborate upon occupational therapy. The war has demonstrated what a valuable therapeutic adjunct it is in the treatment of convalescent patients, especially for those whose troubles are of a nervous nature. The profession in private practice should not be the last to recognize that such training is imperative in certain cases and the obligation to provide for it is clear.

EDITORIAL FROM A COUNTRY PAPER.

EVERY week we read a journal that is devoted quite hotly to medical freedom. Judging from what this seven-day periodical of enlightenment has to say, we are in great danger of a vast medical trust, that will sit heavily and ruthlessly upon us, poisoning us with deadly serums and vaccines, gagging us with nauseous decoctions of mephitic herbs.

Is there really anything the matter with our present medical freedom in this country? Is there any dam fool "ism," any absurd claim, any sort of "Eny, Meny, Miney, Mo" business that we cannot try upon our diseased and tortured bodies if we are so minded?

Truth compels us to answer, None.

Consider for a minute what has been done by the regular school of medicine against which, in the name of freedom, we are so vociferously and so repeatedly warned. Then consider the achievements of the various schools, cults, 'isms and creeds that would supplant this profession and consign it to forgetfulness.

The regular school of medicine is fallible. There are many things it cannot do. But it never ceases in its search for truth. The laboratory and the clinic room are its foundation and inspiration. Nothing is taken for granted. It bases its deductions upon scientific facts, that must overcome the combined force of prejudice, tradition and vested interest.

What has become of cholera? What has become of infant diarrhea? What has become of smallpox, once a terror equal to plague? What has become of diphtheria and membranous croup? Who is gradually conquering tuberculosis, the greatest of human plagues? Who has dissipated the dread specter of hydrophobia? Who achieved the marvels of modern surgery? Has it not been the school of regular medicine? One by one, hostile schools of healing have been reared to combat the ancient profession of Hippocrates. Where are they now? Only echo answers, Where?

Who is frantically and supplicatingly in demand

upon those long battle lines in Europe? Is it chiropractics? Is it osteopaths? Is it Christian Science healers?

Those who seek to overthrow the regular practitioners found their assumptions upon a combination of superstition, and a wooden-faced denial of physical facts. They come and go like the passing seasons. They make no great scientific discoveries. They garner no tomes of physical knowledge. They are found in the end to be based upon pretence, gullibility, superstition and esoteric moonshine.

The regular school makes mistakes. It needs watching. It should never emerge to that haughty eminence where it will not receive its full quota of brain-clearing, humility-preserving kicks; but forget not, brethren, it is the salt of the earth, and suffering humanity's one dim and distant star of hope.—*Lamar (Mo.) Democrat.*

War Savings Stamps are within the reach of everyone who conscientiously wants to save.

REPETITION AND REITERATION.

DON'T complain if from time to time you see on this page or in the publication of your county society the "same old stuff" about prompt payment of dues, bringing in new members, duties to county and state societies, etc. They really are not intended for your eyes, for of course you are prompt and devoted in all your obligations as mentioned above. And as always the willing horse must do more and more work, so we secretaries hope that you will forgive the monotony of these repetitions and accept a new task, namely, that of conveying by word of mouth these messages to the ears of our members whose eyes rarely, if ever, behold the handiwork of our pens. We know that 20 per cent of our members never open these publications, and that a much larger percentage, having opened and read, promptly forget. So you, having perused these references to the bitter end, are again importuned to increase the interest in all topics vital to organized medicine and to realize our justification in "harping away" on such dull lines.—*Exchange.*

MEDICAL MOBILIZATION AND THE WAR

WAR NOTES

Dr. A. W. James of Muscoda, on active duty in France, has been promoted to the rank of captain.

Dr. George H. Dickenson of Milwaukee has returned from Humphreys, Virginia, having received an honorable discharge.

Lieutenant L. E. Beringer of Camp Custer, visited in Plymouth early in January.

Captain C. U. Senn of Ripon visited at his home recently on an extended leave of absence.

Captain Gentz Perry of Amery has been presented with the distinguished Croix de Guerre for fearless bravery and excellent executive ability shown on the battle-fields of France. Captain Perry has been in the service about a year and a half, having been stationed at Pittsburg and at Camp Greenleaf before being ordered abroad.

Dr. W. C. Watkins of Oconto, who left with Company M, has been promoted to the rank of major.

Dr. John L. Yates of Milwaukee has arrived in New York from France.

Dr. James P. Dean, who enlisted with field hospital number 127 has been promoted to a captaincy. He is now with the 32d Division with the Army of Occupation, Coblenz.

HONORABLE DISCHARGES, MEDICAL CORPS, U. S. ARMY.

C. O. Richards, Rhinelander.
David Mehigan, Milwaukee.
S. E. Gavin, Fond du Lac.
Walter G. Darling, Milwaukee.
H. T. Schlegal, Wausau.
George Parke, Viola.
G. E. Armstrong, New London.
W. H. Bayer, Gleason.
R. J. Goggins, Oconto Falls.
C. S. Brewer, Fort Atkinson.
H. G. Mertens, Bayfield.
F. L. Griswold, Mazomanie.
H. E. Schmidt, West Allis.
D. B. Dishmaker, Kewaunee.
P. R. Minahan, Fond du Lac.
C. N. Stuesser, Alderly.
Philip Fox, Milwaukee.

Geo. H. Dickenson, Milwaukee.
W. F. Whyte, Madison.
H. E. Burger, Beloit.
G. E. Bilstad, Cambridge.
M. A. Bailey, Fennimore.
P. G. McCabe, Fond du Lac.
P. R. Minahan, Fond du Lac.
A. M. Rosenheimer, Fox Lake.
R. R. Rath, Granton.
L. J. Simon, Horicon.
K. W. Smith, Madison.
C. L. R. MacCollum, Manitowoc.
J. J. Eisenberg, Milwaukee.
P. A. Fox, Milwaukee.
H. L. Nahim, Milwaukee.
P. M. Ross, Milwaukee.
R. C. Westhofen, Milwaukee.
A. J. Gates, Tigerton.
W. A. Ladwig, Wausau.
E. R. Murphy, Antigo.
J. A. Palmer, Arcadia.
L. W. Sayles, Baraboo.
E. L. Mason, Eau Claire.
T. W. Nuzum, Janesville.
W. A. Edwards, La Crosse.
R. M. Hall, Milwaukee.
J. F. Wenn, Milwaukee.
G. E. Armstrong, New London.
A. J. Loughnan, Oconomowoc.
G. N. Brazeau, Racine.
E. J. Knapp, Rice Lake.
P. J. Majerus, Sullivan.
R. L. MacCormack, Alma Center.
A. D. Andrus, Ashland.
J. M. Mecum, Bagley.
Roger Cahoon, Baraboo.
H. Kalling, Black River Falls.
F. H. Baldwin, Bloomington.
C. F. Myre, Boyd.
L. A. Hoffman, Campbellsport.
E. X. Thompson, Cudahy.
F. H. Ferguson, Elroy.
L. J. Bennett, Fort Atkinson.
M. J. Treichler, Hancock.
F. E. Shearer, Janesville.
J. W. Adair, Kenosha.
V. C. Jacobson, La Crosse.
S. Berglund, Marinette.
J. W. Boren, Marinette.
R. F. Braun, Milwaukee.
L. J. Foley, Milwaukee.
W. E. Fox, Milwaukee.
J. J. Heffron, Milwaukee.
W. G. Hyde, Milwaukee.
G. T. Savage, Milwaukee.
L. P. A. Valentine, Milwaukee.
C. A. Hefty, New Glarus.
C. H. Andrews, Platteville.
J. Anderson, Racine.
F. C. Christensen, Racine.
J. T. Corr, Racine.
E. C. Cary, Reedsville.
C. M. Beebe, Sparta.
J. M. Conway, Spring Valley.
E. Charbonneau, Superior.
V. E. Ekblad, Superior.
W. E. Hatch, Superior.
W. C. Reineking, Wales.

ORDERS TO OFFICERS, MEDICAL CORPS, U. S. ARMY.

To Camp Jackson, S. C., Emerson Field, from Americus, Ga., Capt. J. J. France, Milwaukee.

To Colonia, N. J., from Walter Reed General Hospital, Capt. J. C. Elson, Madison.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to Camp Upton, N. Y., base hospital, from Camp Pike, Lieut. A. Yaffe, Milwaukee.

To Fort Sheridan, Ill., from Camp Hancock, Capt. E. L. Bolton, Chilton; from Camp MacArthur, Lieut. J. D. Gillis, Wauwatosa.

To San Francisco, Calif., Letterman General Hospital, from Jefferson Barracks, Capt. G. H. Lawrence, Fond du Lac.

To Fort Snelling, Minn., from New Haven, Lieut. L. R. Fowzer, Manawa.

The following order has been revoked: To Camp Gordon, Ga., to examine the command for cardiovascular diseases, from Fort Oglethorpe, Lieut. R. E. Fitzgerald, Milwaukee.

To Azalea, N. C., from Fort Oglethorpe, Lieut. R. L. Prees, Cambria.

To Camp Sevier, S. C., base hospital, from Fort Oglethorpe, Capt. R. J. Goggins, Oconto Falls.

To Camp Sherman, Ohio, as tuberculosis examiner, from Camp Pike, Capt. H. C. Caldwell, St. Croix Falls.

BOOK REVIEWS

Surgical Treatment. Volume II. A practical treatise on the Therapy of Surgical Diseases for the use of practitioners and students of surgery. By James Peter Warbasse, M. D., formerly attending surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo volumes, and separate Desk Index Volume. Volume II contains 829 pages with 761 illustrations. Philadelphia and London. W. B. Saunders Company. 1918. Per set (three volumes and the index volume), cloth $30.00.

Volume II of "Surgical Treatment" is fully up to the expectations created by Volume I of this excellent treatise on general surgery reviewed in a recent issue of the Journal. The scope and general plan of the work was given in this review. This volume takes up the treatment of injuries and diseases of the scalp, skull, eye, nose, naso-pharynx. larynx, trachia, mouth, ear, spine, neck, the thorax and organs contained, the breast and the abdomen, some 300 pages being given to the latter subject alone.

Each of the organs is taken up under the general heading and, as a sub-head, the field covered by a thorough consideration of injuries, diseases, and treatment. The work continues a complete textbook in every way, yet avoids unnecessary detail and impresses the reader with its practicability. It is exceptionally well illustrated and merits our unqualified approval as a practical general textbook on surgical treatment.

MENTAL DISEASES. A handbook dealing with Diagnosis and Classification. By Walter Vose Gulick, M. D., Assistant Superintendent Western State Hospital, Fort Steilacoom, Washington. Illustrated. C. V. Mosby Company, St. Louis. 1918. Price, $2.00.

This little handbook is not in any way intended as a textbook on mental diseases but rather as a handbook for the general practitioner who is occasionally called into court or required to conduct office or public examinations of the insane. It briefly outlines the classification of mental diseases adopted by the American Medico-Psychological Association in May, 1917, which has been accepted for use in the War Department.

A chapter is given to examination methods and then a brief chapter on the various forms of mental disease in the order of their frequency. Illustrations of typical types of these forms are given throughout the work. This book will be of value to those who wish to gain a superficial knowledge of the subject.

PATHOLOGICAL TECHNIQUE. A practical manual for workers in Pathologic Histology and Bacteriology. Including directions for the performance of Autopsies and for clinical diagnosis by laboratory methods. By F. B. Mallory, M. D., Associate Professor of Pathology, Harvard Medical School; and J. B. Wright, M. D., Pathologist to the Massachusetts General Hospital. Seventh edition, revised and enlarged. Octavo of 555 pages with 181 illustrations. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $3.75.

The seventh edition of this valuable work has been carefully revised and re-arranged. Among other changes, post-mortem technique has been put at the end. Many new methods have been added here and there, such as the safety razor blade in section cutting, the employment of benzine in parafine embedding, Rubaschkin's method of fixing celloidin and frozen sections to the slide for staining, etc.

The book is designed for practical use in pathological laboratories, both as a guide to beginners and as a source of reference for the advanced. It will also be of value to any practitioner who has opportunity to do general pathological work. The ground is covered under the following general divisions: Histological methods, culture media, culture methods, methods of staining bacteria, pathogenic bacteria and fungi, animal parasites, clinical pathology, and post-mortem examinations.

A MANUAL OF DISEASES OF THE NOSE, THROAT AND EAR. Fourth edition. Thoroughly revised. By E. B. Gleason, M. D., Professor of Otology in the Medico-Chirurgical College Graduate School. University of Pennsylvania. 12mo of 616 pages, 212 illustrations. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $3.00 net.

The third edition of Doctor Gleanson's work has been carefully revised and brought up to date without lengthening the text to a point where it could no longer serve as a manual to supply students and general practitioners with the essential facts on the subject in a concise form. The work is not designed as a reference for specialists but rather as a handy manual for general practitioners and beginners in the study. Wherever a condition for which operations are sometimes done is amendable to treatment, description of the treatment receives the more careful elaboration. Anatomy, physiology, and pathology receive careful consideration. The details of examination and diagnosis are carefully described and the same may be said of minor operations. A collection of formulas is published at the end of the book. The work is illustrated with 262 engravings, mostly original.

PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, A. M., M. D. Professor of Obstetrics at the Northwestern University Medical School. Third edition, thoroughly revised. Large octavo of 1089 pages, with 949 illustrations, 187 of them in colors. W. B. Saunders Company, Philadelphia and London. 1918. Cloth. $8.50, net.

Here is a great book. Also a large one. 1000 pages. But readable, stimulating, interesting and informing, from cover to cover. It is a book which reflects opinions which the author has formulated after an experience of twenty-one years; rich and rare experience in hospital, dispensary, consultation and private practice.

This is the author's third edition and while there is not a great difference between this and the second edition—still there are many subjects which have been revised and amplified.

Recent contributions to the science of obstetrics have been tried out and those which have "made good," in the author's estimate, have been given a proper place and setting in this new edition.

This book has a wealth of illustrations—949 in number—and 187 of these are in colors. These illustrations are of the finest and the author frequently illuminates an operation or an obstetrical procedure by means of these, in successive steps, rather than resorting to long and tiresome descriptions.

The following subjects have been amplified in this new edition: Obstetrical anesthesia and anelgesia, perineorrhaphy, cesarian section, eclampsia, twilight sleep, rectal examinations, and Abherhalden's pregnancy reaction. The reviewer of this book is a "general practitioner" and as such commends it most highly to such as he. The discussion of the subject "twilight sleep" and the author's conclusions are worth the price of the whole work. The author has evidently had in mind the great body of men in general practice and the fact that they, and not the obstetrical specialists, will have charge of great majority of obstetrical cases and so he has made this work especially illuminating, practical and informing to them and to students who will soon be general practitioners.

To those of an investigative turn of mind sufficient recent references are given to enable them to find all the literature.

Lengthy bibliographies have been avoided.

S. D. B.

Pro-Germans probably think the War Savings Campaign a foolish one.

ABSTRACTS

THE ARMY SHOE. J. T. Rugh, Philadelphia (*Journal A. M. A.*, Oct. 12, 1918), says that the result of extensive foot inspections in 1917 and 1918 show that marked changes have occurred in the feet of recruits, and verify the experience of civil orthopedic practice. The changes have been almost invariably favorable, and the two most potent factors are the Army shoe and the increased personal care and interest in foot health developed in officers and men. Extensive observations covering several hundred thousand cases show that 98 per cent of the recruits can be fitted with the Army shoe. A properly fitted shoe at the beginning of service should have about two-thirds inch between the end of the longest toe and the end of the shoe. After from four to six months of training there should be at least half an inch. The heel should be held fairly snug in the shoe, the vamp should fit smooth over the forefoot, and the ball of the foot should rest in its seat, near the posterior turn of the sole. In fitting shoes, it must be remembered that they will enlarge sidewise but never lengthwise, also that repairing tends to shorten a shoe, and rebuilding actually does shorten it. Short shoes cause more trouble than long ones, and the correct length and breadth of shoe permits a degree of function hitherto unknown to the foot. "There is greater freedom of toe action, which effects both muscles and joints. This is followed directly by lengthening of ligaments, increase in size of muscles and alteration of relations of all the anatomic elements of the foot. These factors contribute directly to an increase in the size of the part. I have repeatedly seen cases in which the original size of the shoe had been strongly objected to as being entirely too large, but after a few months of intensive training and perhaps using extra or thicker socks, the fit was entirely satisfactory by reason of the development of the foot. With the greater freedom of action in the larger shoe, there occurs absence of pressure on toe-joints, and corns disappear. There is freedom from pressure on nails, and 'ingrowing' gradually ceases, especially if a little aid is given by cutting and attention. Toes that have been crowded together have sufficient room for normal function, and under the constant muscle pull and better distribution of weight, both of which forces are almost constantly active in the soldier's foot for from twelve to fourteen hours a day, they gradually assume a normal relation. In many instances, a moderate degree of overlapping has gradually lessened to a very nearly normal position. Similar results obtain in various other conditions in which secondary pathologic changes have not produced a degree of performance that will yield only to surgery. These superficial conditions are always of mechanical origin, and almost universally from improper foot coverings, not from faulty function primarily. When, therefore, these mechanical conditions are remedied or removed, the effects disappear and the part gradually develops into as nearly normal a state as is compatible with existing pathologic changes of conditions." With the greater freedom of action in the properly shaped shoe the muscles of the foot increase in size, and the transverse and longitudinal arches are maintained, circulation improves, the leg muscles also share in the advantages. The regulation Army shoe has all the essential qualities for foot health, and the education of the soldier in the proper care and use of his feet will have its reaction on the general health of the population.

It is evident, therefore, that so far as the supply of physicians is concerned, there is clearly no danger of a shortage being produced by the present world war even if we should be called on to supply the needs of some of our allies. Consequently there is positively no basis for arguments favoring the reduction of educational standards. As a matter of fact, our medical colleges might all be closed for several years and the annual supply of physicians entirely cut off, and the number of physicians in the United States would still remain in a higher proportion to the population than in the most favored country of Europe. The only valid reason why medical schools should be kept going is that in recent years they have turned out physicians who are eminently better qualified than those of earlier years, and this one reason would be removed if educational standards should be lowered. It is only during the last eight or ten years that the majority of medical graduates each year have had the benefit of higher preliminary qualifications, of better equipped laboratories, of better hospital facilities, and of a training under larger numbers of full time, salaried, expert teachers. Our superabundance of physicians is mostly made up of those who did not have the benefit of these greatly improved conditions in medical schools, many of whom, however, be it said to their credit, through graduate courses and study, have kept up with the advances made in medical knowledge.

Those who are arguing for a reduction in standards on the plea that there is a need of physicians are either misinformed in regard to the facts or have certain special interests which they are striving to uphold. In the light of these facts it is urged that licensing boards generally enforce the present reasonable standard of two years of collegiate work as the minimal requirement of preliminary education. The argument that there is a dearth of physicians should not be looked on as an excuse for lowering educational standards in the interest of any pseudomedical cult. Let the present educational standards, which have been successfully established in recent years, be upheld so that the name of America, from the standpoint of medical education, may retain the high position educationally that it has recently attained among civilized nations.—*Jour. A. M. A.*, Oct. 12, 1918.

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[1]We have not included in these calculations the thousands of osteopaths, chiropractors, naprapaths, physcultopaths, and other cult practitioners who, outside of the United States and Canada, are not to be found in other countries.

If the men in our Army and Navy can do without luxuries we at home certainly can.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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L. A. POTTER, Superior, 2nd Vice President

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3rd Vice President
ROCK SLEYSTER, Waupun, Secretary

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Ass't Secretary
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TERM EXPIRES 1919

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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES.

County.	President.	Secretary.
Ashland-Bayfield-Iron	J. V. Wenzel, Ashland	C. J. Smiles, Ashland.
Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
Brown-Kewaunee	J. F. Gosin, Green Bay	E. S. McNevins, Green Bay.
Calumet	H. C. Krohn, New Holstein	F. P. Knauf, Kiel.
Chippewa	G. M. Smith, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	W. H. Sheldon, Madison	H. P. Greeley, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	A. G. Hovde, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	R. F. Werner, Eau Claire	R. E. Mitchell, Eau Claire.
Fond du Lac	C. W. Leonnard, Fond du Lac	D. N. Walters, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	Brand Starnes, Mauston	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	H. E. Wolf, La Crosse	Sara Nimocks, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Shockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	J. E. Meany, Manitowoc.
Marathon	A. B. Rosenberry, Wausau	F. H. Frey, Wausau.
Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. J. Kaumheimer, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	S. D. Beebe, Sparta	T. J. Sheehy, Tomah.
Oconto	C. W. Stoelting, Oconto	Minnie Hopkins, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	E. R. Boyer, Rhinelander.
Outagamie	M. J. Sandhorn, Appleton	G. T. Hegner, Appleton.
Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
Pierce	W. A. Lumley, Ellsworth	Rollo Cairns, River Falls.
Portage	J. D. Lindores, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	E. A. Riley, Park Falls	G. C. Wichman, Rib Lake.
Racine	J. G. Meachem, Racine	Susan Jones, Racine.
Richland	R. H. Delap, Richland Center	G. Benson, Richland Center.
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Rusk	J. C. Baker, Hawkins	L. M. Lundmark, Ladysmith.
Sauk	F. D. Hulburt, Reedsburg	Roger Cahoon, Baraboo.
Shawano	A. J. Gates, Tigerton	W. H. Cantwell, Shawano.
Sheboygan	H. C. Reich, Sheboygan	T. J. Gunther, Sheboygan.
St. Croix	B. Kunny, Baldwin	O. H. Epley, New Richmond.
Trempealeau-Jackson-Buffalo	E. A. MacCornack, Whitehall	C. F. Peterson, Independence.
Vernon	J. K. Schreiner, Westby	F. E. Morley, Viroqua.
Walworth	M. D. Cottingham, Lake Geneva	E. Kinne, Elkhorn.
Washington	H. F. Weber, Newburg	A. H. Heidner, West Bend.
Waukesha	G. E. Peterson, Waukesha	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Wanpaca	G. T. Dawley, New London.
Winnebago	F. G. Connell, Oshkosh	H. W. Morgenroth, Oshkosh.
Wood	J. C. Hayward, Marshfield	Wm. Hipke, Marshfield.

SOCIETY PROCEEDINGS

BROWN-KEWAUNEE COUNTY

At the annual meeting of the Brown-Kewaunee County Medical Society, the following officers were elected for the ensuing year: Dr. D. F. Gosin, President; Dr. N. M. Kersten, Vice-President; Dr. E. S. McNevins, Secretary and Treasurer; Dr. J. J. Robb, Censor; Dr. W. E. Fairfield, Delegate; Dr. O. A. Olmstead, Alternate.

E. S. McNevins, M. D., *Secretary.*

DUNN-PEPIN COUNTY.

The annual meeting of the Dunn-Pepin County Medical Society was held in Menomonie, January 23, 1919. The Society re-elected the 1918 officers for the ensuing year.

N. L. Howison, M. D., *Secretary.*

EAU CLAIRE COUNTY.

The regular monthly meeting and annual election of officers was held Monday evening, January 27, 1919, at the Galloway House. The following program was given:

Annual Election of Officers.

Dr. E. L. Mason—Review of Influenza Epidemic at Camp Dodge.

Dr. W. O. Seemann—Camp Experiences.

R. E. Mitchell, M. D., *Secretary.*

FOND DU LAC COUNTY

The monthly meeting of the Fond du Lac County Medical Society was held at the Elks' Club House, January 15, 1919, at 8:30 P. M. The Fond du Lac County Board was invited to attend, which they did in a body.

The meeting was called to order by President C. W. Leonnard, and the proposition of a Fond du Lac County Isolation Hospital was put up to the board.

Addresses were given by Drs. C. W. Leonnard, F. S. Wiley, D. J. Twohig, S. S. Hall, and G. B. McKnight, in which the needs of an institution of this kind was forcibly expressed. Dr. F. M. McGauley, city health officer of Fond du Lac, read a letter written to him by Dr. Harper, the state health officer, giving statistics showing the mortality rate due to communicable diseases in counties which have an isolation hospital and those which have none. A very decided increase was shown in those which have no institution of this kind and a very low percentage in those which have an isolation hospital. Several members of the County Board were called upon to give their views and opinion on the subject and all spoke very favorably of it.

At 10:30 P. M. the meeting was adjourned and all retired to the Grill Room where a very appetizing luncheon was served and a cabaret furnished amusement for the balance of the evening.

D. N. Walters, M. D. *Secretary.*

LANGLADE COUNTY

The Langlade County Medical Society held its annual meeting at the Hotel Butterfield January 18th. A banquet was served in the main dining room at 6:30, consisting of a five course dinner, and Landlord Butterfield surely did himself proud for the elegant repast, consisting of fish, fowl, salads, fruits, etc., which had a tendency to sharpen the appetite. As a rule the doctors are good feeders and on this occasion were no exception. They all enjoyed the repast, and the banquet of 1919 will be remembered, not forgetting the doctors who are away and did not have the opportunity of being with us.

After the banquet the society held its business meeting and smoker. The meeting was called to order by the vice-president, Dr. I. D. Steffen, the president, Dr. E. J. Donohue, being unable to be present. After the preliminaries, business matters were taken up. A resolution was passed asking our state senator and member of the assembly to do all they could to have the Coe bill passed, which is the adoption of the wide sleigh bill, which would aid much in allowing us to run our cars practically all winter. A resolution was passed that all obstetrical work be cash. A resolution was passed that the county and state dues be paid for all doctors belonging to our society, who are now in the service.

The meeting was a harmonious one and all doctors present seemed to have the spirit of kindest regard for the profession and each other, and after the past four months of strenuous work are now beginning to relax and forget the sleepless nights and hard mental strain that has been placed upon them. So harmonious was the meeting that it was moved, seconded and carried that the old officers, who have held offices during the past year, be re-elected for the coming year. Dr. Wright was chosen delegate to represent the Langlade County Medical Society at the State Medical Society meeting in Milwaukee in October. Records show that every doctor in the county is in good standing in the state and county medical societies, an honor that cannot be said of any other county in the state, and it speaks much for the profession—that the society must be working together and everyone willing to do his part in making the profession a success. Dr. Helen Beattie Tennies was gladly accepted into our society again after several years' absence from our city.

J. C. Wright, M. D., *Secretary.*

MILWAUKEE COUNTY. MEDICAL SOCIETY

The first regular meeting of the Society of 1919 was held at the Hotel Wisconsin on Friday evening, January 10th, at 8:30 o'clock. The following program was presented:

Acute Ileus, with Illustrative Cases—By Dr. C. M. Echols.

The rest of the meeting was devoted to the reporting of clinical cases.

Daniel Hopkinson, M. D., *Secretary.*

MILWAUKEE MEDICAL SOCIETY

At the annual meeting of the Milwaukee Medical Society, held in the Colby-Abbot building January 14, Dr. H. E. Dearholt was elected president to succeed Dr. Richard Dewey. Other officers elected are: Vice-president, Dr. D. E. W. Wenstrand; second vice-president, Dr. A. L. Kastner; secretary, Dr. Oscar Lotz; treasurer, Dr. J. P. McMahon; librarian, Dr. W. LeCorn; curator, Dr. G. A. Garhart. Council members named were: Dr. H. M. Brown, Dr. L. F. Jermain, Dr. George C. Ruhland, Dr. F. C. Studley, Dr. George Fellman and Dr. H. W. Powers.

MILWAUKEE EYE, EAR, NOSE AND THROAT SOCIETY.

At the annual meeting of the Milwaukee Eye, Ear, Nose and Throat Society, held at the University Club January 8, the present officers were re-elected, as follows: Dr. Samuel G. Higgins, president; Dr. William E. Grove, vice-president; and Dr. William S. Stanley, secretary. The increased fee schedule recommended last year was adopted.

MARATHON COUNTY

Dr. A. B. Rosenberry was elected president of the Marathon County Medical Society January 12 to succeed Dr. W. E. Zilisch, whose term of office has expired. Dr. Jackson of Mosinee was elected vice-president and Dr. Forrest H. Frey was re-elected secretary-treasurer. Dr. W. E. Zilisch was selected as delegate to attend the next annual meeting of the Wisconsin State Medical Society, and Dr. S. M. B. Smith was chosen alternate. Dr. W. A. Green was elected censor. The meeting was held at the Wausau club.

NINTH COUNCILOR DISTRICT.

The winter meeting of the Ninth Councilor District Medical Society was held at Marshfield, Thursday, January 30, 1919. The program was as follows:

Clinical meeting at St. Joseph's Hospital—2:30—6:00.

Luncheon.

Evening program: 1. "Importance of the Early Diagnosis of Pulmonary Tuberculosis"—Dr. A. E. MacMillan, Stevens Point. Discussion by Dr. D. Waters, Grand Rapids.

2. "Medical Experiences in the Army Cantonments"—Dr. H. T. Schlegel, Wausau.

3. "Medical Experiences Among the War Refugees in France"—Dr. S. M. B. Smith, Wausau.

JOSEPH F. SMITH, M. D., *Secretary.*

OUTAGAMIE COUNTY.

The regular monthly meeting of the Outagamie County Medical Society was held at the Y. M. C. A. Jan. 21st, 1919. This being the first meeting of the year, a business meeting was held at 5 P. M., at which the following officers were elected for the ensuing year: President, Dr. M. J. Samborn, Appleton; Vice-President, Dr. C. J. Maes, Kimberly; Secretary and Treasurer, Dr. G. T. Hegner, Appleton; Censor, Dr. A. E. Rector, Appleton; Delegate, Dr. C. D. Boyd, Kaukauna; Alternate, Dr. E. W. Cooney, Appleton. Following this a supper was served at 6:15 after which Dr. C. J. Maes of Kimberly read a paper on "Hand Injuries," and Dr. N. P. Mills of Appleton read a paper on "Hand Infections." Both papers were very practical and highly instructive and much appreciated. The discussion following was full of "pep" which is characteristic of Outagamie County.

GEO. T. HEGNER, M. D., *Secretary.*

SHAWANO COUNTY

The annual meeting of the Shawano County Medical Society was held in Shawano January 15. The following officers were chosen for the coming year: President, Capt. A. J. Gates of Tigerton; vice-President, Dr. Ragan of this city; secretary and treasurer, Dr. H. Cantwell of this city; censor, Dr. Terlinden of Bonduel; delegate to the State Convention, Dr. Ragan; alternate, Dr. Rothman.

TREMPEALEAU-JACKSON-BUFFALO COUNTY

On account of war activities, only one meeting was held in 1918, on May 15, at Arcadia, Wisconsin.

Besides the usual routine business, Dr. H. A. Jegi of Galesville addressed the meeting on the subject of "First Aid." He recommended the organization of a class in each town under the direction and instruction of a physician. Dr. E. A. MacCornack of Whitehall read a paper on "Peptic Ulcers." He cites three important cases in his own practice on which he operated at the Whitehall Hospital.

The annual meeting, usually held in December, was postponed until January 22, 1919, the epidemic of influenza and pneumonia prevailing in this district. The Society met at Arcadia at one P. M. There were eight members present. Dr. J. A. Palmer of Arcadia, who has just been discharged from the U. S. Army service, acted as chairman of the meeting.

The report of the Secretary-Treasurer was read and adopted, as was that of the delegate. The Society voted to pay the state dues for its members now serving in the army. Dr. R. J. Drew of Alma Center was elected to membership.

The following officers were elected by acclamation: Dr. E. A. MacCornack, Whitehall, President; Dr. A. C. Edwards, Arcadia, Vice-President; Dr. C. F. Peterson, Independence, Secretary-Treasurer; Dr. C. F. Peterson, Independence, Delegate; Dr. H. A. Jegi, Galesville, Alternate; Dr. J. P. Reinhardt, Fountain City, Censor.

Discussion—Epidemic of Influenza-Pneumonia. Meeting then adjourned.

C. F. PETERSON, M. D., *Secretary.*

WINNEBAGO COUNTY

At the annual meeting of Winnebago County Medical Society, held January 15, 1919, the following officers were elected for the year 1919; Dr. F. Gregory Connell, President; Dr. John Schneider, Vice-President; Dr. H. W. Morgenroth, Secretary and Treasurer; Dr. T. D. Smith, Censor (for three years); Dr. Geo. H. Williamson, Delegate; and Dr. Burton Clark, Alternate.

WOOD COUNTY.

The Wood County Medical Society met at Grand Rapids on January 17, 1919. Dr. J. C. Hayward of Marshfield was elected president; Dr. E. E. Whitehorne of Vesper, vice-president; Dr. Wm. Hipke, Marshfield, secretary.

The meeting was held in the Wood County Bank Building. The recent epidemic of influenza furnished the principal subject for discussion. After the meeting the members were entertained at a luncheon at the Elks' Club.

ASSOCIATION NEWS

ANNUAL CONGRESS ON MEDICAL EDUCATION AND LICENSURE.

The next Annual Congress on Medical Education and Licensure, participated in by the Council on Medical Education of the American Medical Association, the Federation of State Medical Boards of the United States, and the Association of American Medical Colleges, will be held at the La Salle Hotel, Chicago, Monday and Tuesday, March 3 and 4, 1919.

On Monday, March 3, the Council on Medical Education of the American Medical Association will hold its Fifteenth Annual Conference. The general topic for discussion will be on "Problems of Medical Education as Revealed by the War." Several prominent medical officers will participate, including Brig.-Gen. E. L. Munson, Lieut.-Col. H. D. Arnold, and Capt. F. C. Waite. Surgeon-Generals Ireland and Braisted, respectively of the Army and Navy, and President Maclaurin of the Massachusetts Institute of Technology have also been asked to present papers.

On Monday afternoon a joint session between the Council and the Federation of State Medical Boards will be devoted largely to a discussion of hospital standardization and the hospital interne year. Prominent leaders in hospital work have been asked to present papers and the discussion will be from the various standpoints of the hospital, the medical college, and the state licensing board.

On Tuesday, March 4, the Federation of State Medical Boards and the Association of American Medical Colleges will hold their annual meetings. In the forenoon there will be a joint session, while the separate business meetings will be held in the afternoon.

You are very cordially invited to attend this series of conferences and to take part in the discussions.

Under the Auspices of the Council of Medical Education of the American Medical Association.

MEETING OF THE COUNCIL OF THE STATE MEDICAL SOCIETY OF WISCONSIN, UNIVERSITY CLUB, MILWAUKEE, JANUARY 13, 1919.

The Council met at the University Club, Milwaukee, Monday, January 13, 1918, at 12:30 P. M.

All Councilors were present at the meeting with the exception of Dr. Redelings, who reported he would be unable to attend.

Those present in addition were President Hayes; Treasurer Hall; Secretary Sleyster; past acting councilor of first district, Peterson; managing editor, McMahon; and Drs. J. S. Evans, L. M. Warfield, Oscar Lotz, G. C. Ruhland, G. J. Kaumheimer, C. H. Lemon.

The different Councilors reported on the organization work in their districts.

Dr. C. H. Lemon, chairman of the Program Committee, extended an invitation to the Society to meet in Milwaukee next October and outlined plans for the 1919 program.

Dr. Kaumheimer, president of the Milwaukee County Society, spoke briefly, urging the advantages of a Milwaukee meeting.

It was moved and carried that the next meeting of the State Society be held in Milwaukee, October 1, 2 and 3, 1919.

Dr. G. C. Ruhland, health commissioner of the city of Milwaukee, appeared before the Council, urging cooperation in extending public health work.

The reports of the secretary, treasurer, and managing editor were read and accepted.

Expense bills submitted by Councilor Windesheim were allowed.

The following officers were re-elected for the coming year: Chairman of the Counsel, Edward Evans, La Crosse; Secretary, Rock Sleyster, Waupun; Treasurer, S. S. Hall, Ripon.

The Chairman of the Council was instructed to forward to the Regents of the State University resolutions expressing the appreciation of the State Medical Society for work done in post-graduate medical instruction.

It was moved and unanimously carried that the Council approved of the attitude of the secretary toward cooperation with the Tri-State District Society.

There being no further business, the meeting adjourned.

ROCK SLEYSTER, *Secretary.*

RESOLUTIONS PASSED BY THE STATE MEDICAL SOCIETY OF WISCONSIN, OCT. 4, 1918.

Whereas, Members of the Wisconsin State Medical Society are pledged to give 100 per cent loyal support to every request as well as order of the United States Government; and

Whereas, Foremost among the requests from the office of the Surgeon General of the Army is the appeal to the physicians to exercise their utmost skill and perseverance in the prevention and care of venereal disease, which is one of the worst factors in contributing to military disability among men otherwise available for service; and

Whereas, There is an order from the Department of Justice which instructs the local police authorities to have all women arrested on disorderly charges or on any charge of violation of other criminal statutes to be examined by a police physician to determine if she is infected with venereal disease, and in case of such infection she is to be held under restraint and medical care until the infection has cleared, and since this order, to which both police and the physicians have been faithfully responsive, has put a prodigious burden upon the capacities of all hospitals, and infirmaries, of jails, houses of correction, etc., to care for these infected women, and the accommodations are in no way adequate; and

Whereas, The institution now in progress of erection at Taycheedah, primarily designed as a reformatory for women offenders between the ages of 18 to 30 years, would, if completed as rapidly as possible, furnish a means up to the limit of its capacity of complying with the purpose of the order of the Surgeon General of the U. S. Army, to all of which the physicians and surgeons of Wisconsin are most eager to give their utmost in point of loyalty and co-operation; now, therefore, be it

Resolved, By the Wisconsin State Medical Society, assembled in Milwaukee, October 3rd, 1918, that in the judgment of this organization its first duty in rendering effective co-operation in this matter is to bring it to the attention of the Governor of the state of Wisconsin with the urgent request that he use his utmost resources to secure the speediest possible availability of the institution at Taycheedah to receive the venereally infected women for whom at the present time the judges of the various courts in the state, acting in compliance with the requests of the Surgeon General, can make no other provision.

CORRESPONDENCE

DEPARTMENT OF LABOR AND INDUSTRY.

Harrisburg, Penn., December 23, 1918.

Wisconsin Medical Journal.

My dear Sir: Will you kindly call attention in the next issue of your Journal to the fact that Dr. Francis D. Patterson, Chief, Division of Industrial Hygiene and Engineering, Department of Labor and Industry, Harrisburg, Pa., is desirous of obtaining a complete list of all physicians engaged in the practice of industrial medicine?

It has been the practice of this Department to hold semi-annual Conferences of Industrial Physicians and Surgeons for several years. These Conferences are well attended, and a great deal of valuable matter is presented in the discussions. In order to reach all physicians interested it is desirable to have their names upon our mailing list. The next Conference will be held early in 1919, and it is, therefore, essential that the names and addresses of all Industrial Physicians and Surgeons be in my hands as soon as possible after January 1st.

Expressing to you my deep appreciation for your courtesy in calling this matter to the attention of your readers, I am,

Very sincerely yours,
FRANCIS D. PATTERSON,
Chief, Division of Hygiene.

AMERICAN RED CROSS, CENTRAL DIVISION.

180 N. Wabash Ave., Chicago, Ill.
December 28, 1918.

Re: Migratory Families of Tuberculous Soldiers.

Wisconsin Medical Journal.

Your attention is called to the following resolution, adopted among others, by the Southwestern Tuberculosis Conference held at Denver, regarding migratory families of tuberculous soldiers:

Whereas, The migratory and careless consumptive constitutes a distinct public health menace, and in the cases of indigent persons such migration is productive of unequal social, financial, and civic burdens; and

Whereas, This problem is one of intimate concern and peculiar significance to the States of the Southwestern Tuberculosis Association; and, therefore,

Be It Resolved, By the representatives of the various cities and states assembled at this Southwestern Conference: Since the paramount principles of the treatment of tuberculosis are proper and adequate care, food, rest and home association, we pledge our efforts to discourage the migration of patients who sacrifice these for the single consideration of climate.

Furthermore, hundreds of men are being discharged with tuberculosis from camps in the east and camps in the west who are being advised even by physicians to "go west" or remain west. These men, as has been found in such states as California, have become a serious social problem.

Your attention is directed particularly to the statements of representatives of climatic states of the southwest most directly affected by this problem of tuberculosis, that it is their conviction that *climate without care, or climate at the expense of care is a most dangerous fallacy in the treatment of tuberculosis.* The leading authorities in the tuberculosis field are agreed that, for

those who can afford it, there is some advantage in living in certain climates. Such authorities are equally emphatic in declaring, however, that tuberculosis can be successfully treated in suitably located sanatoria in every state in the union. Unless a patient can afford to set aside seventy-five to a hundred dollars a month for a period of at least twelve months in addition to his railroad fare and in addition to the living expenses of his family, it is extremely dangerous for him to go from the East to the Southwest for treatment.

NEWS ITEMS AND PERSONALS.

Dr. Wm. F. Whyte, president of the State Board of Health, who, though beyond the age limit, served thirteen months as a contract surgeon, has been honorably discharged and has returned to Madison. Doctor Whyte served at Fort Benjamin Harrison, Camp Custer, Camp Greenleaf, and Camp Dix, working on tuberculosis boards.

The annual report of St. Saviour Hospital, Portage, shows a total of 579 cases treated during the past year.

Legislation is pending at Madison which will change the laws relating to marriage enacted a few years ago and which have aroused much criticism.

The influenza epidemic which swept the country during the latter part of last year shows a total of 111,686 deaths in the 46 larger cities, and increased the combined death rate in those communities to 19.6 per thousand, according to statistics made public by the census bureau.

The Supreme Court of United States has upheld the section of Wisconsin's pure food law forbidding the retail sale of canned goods containing benzoate of soda.

Dr. H. W. Aldridge of Manitowoc has closed his branch office at Two Rivers.

The directors of Mercy Hospital, Delavan, have under consideration the question of building an addition to the present institution. A total number of 882 patients were received during the past year.

The plans for the Jefferson County tuberculosis sanatorium are nearing completion. The building will be 210 feet long and 24 feet wide and will accommodate fifty patients. It will be modern in every particular. To insure perfectly dry surroundings a complete system of drainage is being installed to drain all ground under and around the building. The work of grading the ground and of excavating has been begun, most of this labor being furnished by the patients of the county asylum and poor house.

Dr. I. F. Thompson of Eau Claire has received a six months' leave of absence as deputy health officer to accept a commission in the U. S. Public Health service. He will be in charge of the social hygiene campaign for Wisconsin.

The city attorney of Milwaukee has handed down an opinion that the city has the right to use part of Emergency Hospital for a free dispensary.

Doctor and Mrs. E. A. Miller of Clintonville left January 7th for Los Angeles, California, where they will spend the balance of the winter.

The physicians of Stevens Point have raised the fees for evening calls to two dollars, the calls coming in after nine o'clock to remain the same as at present, three dollars. This was done in an effort to induce people to call their doctor generally earlier in the evening.

Dr. F. J. Shook, formerly of Pearl City, has formed a partnership with Doctor Kellar of Warren.

The death rate of influenza in Milwaukee is lower than in any other city in the United States, according to figures received from the Surgeon General's office, Washington.

The annual report of St. Mary's Hospital, Superior, shows a total of 2795 patients received during the past year.

Rabies has been present during the past month in Milwaukee, Waukesha, Dane, Washington, Jefferson, Racine, Vernon, Ozaukee, Rock, and Walworth Counties. Since last July the state laboratory has received from these counties the heads of twenty-one animals. Eight of these gave positive findings. Dr. W. D. Stovall, director of the state laboratory, states that the disease is costing the live stock industry of the state large sums of money.

In a malpractice suit of Clarence Van Wegner against Dr. W. G. Doern of Milwaukee, circuit judge John Gregory reversed the findings of the jury and found in favor of the defendant, Doctor Doern.

Dr. G. R. Egland of Sturgeon Bay left for a vacation trip to California on January 21st.

Dr. W. T. Turner of Frederick changed his plea to "guilty" of violating the espionage act and Judge Sanborn imposed a fine of $1,000 upon him, which the doctor paid. Dr. Carl DeSombre of Medford pleaded "not guilty" to the same charge and was released on bail.

Dr. J. M. Dodd of Ashland has been re-elected chairman of the board of directors of the Ashland General Hospital Association.

The Bay View Hospital in Milwaukee has been closed as the emergency incident to the epidemic has been controlled.

There has been considerable agitation in Milwaukee over combining the medical work done in the public schools with the city health department.

Doctor and Mrs. J. S. Walbridge of Berlin have left for California.

One-fifth of the children attending the third street school in Milwaukee were found to be seriously under weight, as shown by an analysis of the result of the weighing and measuring tests just completed, as one of the fore-runners in the establishment of the school's demonstration nutrition clinic with its band of fifty food scouts.

Dr. Walter J. Meek has been elected a director of the Madison General Hospital at a recent meeting. 313 cases were admitted to the hospital during December. The Hospital has received the beautiful bronze tablets ordered some time ago and upon which appear the names of those who have given large sums to the hospital.

Until legislation permits counties of less than 250,000 population to appropriate funds toward the erection and maintenance of isolation hospitals, the plans for the establishment of such an institution in connection with St. Agnes Hospital, Fond du Lac, will have to be held in abeyance. Senator Pullen will endeavor to have the law amended to allow of the immediate construction of such a hospital.

The formal opening of the new Columbia hospital, Maryland and Hartford avenues, Milwaukee, was held Sunday afternoon, Jan. 9. Hundreds of persons inspected the new building, which is said to be the best equipped in the United States. According to John W. Mariner, member of the board of directors, the hospital will be open to the public, not being restricted to any set or creed of people. Several hundred floral offerings, including an elaborate spray sent by the directors of Mt. Sinai hospital, were received in honor of the formal opening. The patients of the hospital will be taken from the old building, Ninth and Sycamore streets, to the new one in ambulances. Those persons whose condition does not warrant their removal will be kept in the old building until they are physically able to be moved.

Dr. R. F. Teschan was elected president of the board of trustees of Emergency hospital at the annual meeting. Ald. Ole Olson was re-elected secretary. Three additions were made to the staff. Dr. J. C. Sargent was elected urologist; Dr. A. L. Kastner was elected to fill the place of Dr. A. W. Myers, deceased, and Dr. Roy Hopkinson was elected oral surgeon. The summary of the hospital report shows the admission of 6,411 patients during the year of 1918.

Dr. Rupert Blue, surgeon of the public health service, has asked the ministers of the country to set aside Feb. 9 as health Sunday and to preach sermons emphasizing the responsibility of the nation to protect returning soldiers and sailors and the community at large, and to inaugurate vigorous measures for combatting social diseases. A proclamation by the surgeon general has been sent to all ministers with the request that they read it from their pulpits Feb. 9.

Dr. Dell Andrus of Ashland left for Oak Island to remain an indefinite period among the lumber camps of the Apostle Islands. His only patients will be the men in the lumber camps of Oak and Stockton Islands. Owing to the isolation of the camps, it is necessary to have a physician on the islands during the spring when the ice is breaking up, and also in the early winter when the ice is forming.

The holiday season marked the first anniversary of the organization of the Polk County hospital, and to celebrate the event the directors and superintendents held open house at which hundreds of residents from Amery and vicinity were in attendance.

Convinced that the establishment of out patient and of occupational departments in connection with county tuberculosis sanatoria will shorten the length of treatment required in many cases and prevent relapses after patients have been discharged as arrested cases, representatives of Wisconsin sanatoria in conference at the offices of the Wisconsin Anti-Tuberculosis association appointed a special legislative committee to secure state legislation authorizing such departments. A resolution instructing the legislative committee to ask that the state aid for county sanatoria be raised from a maximum of $5 a week to $7 a week, owing to increased maintenance costs, was also passed unanimously. H. E. Marquardt, representing the Marathon county sanitarium, was made chairman of the legislative committee on which the other members are F. F. Kress, Brown County; A. S. Titus, Racine County; C. R. Thompson, La Crosse County, and Dr. H. G. Nixon, Waukesha County. T. J. Werle, representing the Wisconsin Anti-Tuberculosis Association, was made an ex-officio member of the committee. Owing to the interest taken during the conference in the discussion of sanatorium problems, it was voted to hold similar conferences of county board supervisors, sanitorium trustees and sanatorium superintendents and physicians semi-annually. Dr. G. Windesheim of Kenosha was elected chairman of the conference and will issue the calls for meetings to which supervisors in counties having no sanatoria, as well as those interested in the administration of local institutions, will be invited. Following the close of the Friday afternoon session delegates to the conference visited Muirdale, the special purpose of the visit being the inspection of the occupational therapy and the out patient departments.

Fourteen members of the senior class of the Marquette University School of Medicine were graduated January 13. The ceremonies were simple, consisting merely of the presentation of diplomas by the Rev. H. C. Noonan, S. J., president of the university. The graduates left for Madison after receiving their diplomas to take the Wisconsin medical state board examinations on Tuesday, Wednesday and Thursday. The class graduates at this time as the result of conducting the medical school through the summer at the government's request. The members of the class are: A. R. Altenhofen, Kewaskum; R. O. Brunkhorst, Milwaukee; E. J. Craite, Rice Lake; R. J. Dalton, Milwaukee; O. M. De Moully, Washburn; W. H. Fritsche, New Ulm, Minn.;

E. H. Gramling, Dousman; N. M. Mauel, Ashford; F. M. Moxon Los Angeles, Cal.; F. S. Selle, Lake Crystal, Minn.; H. A. Shearer, Edgerton; V. J. Taugher, Wausau; F. T. Weber and E. G. Welke, Milwaukee.

The entire class received the degree of bachelor of science in medicine two years ago.

With a view to giving Milwaukee's future generation the proper start in life, an entire floor has been set aside at the new Columbia Hospital, Hartford and Maryland avenues, for obstetrical purposes. It is said that it will constitute the most scientifically and completely equipped department of the kind in the northwest.

DEATHS

Dr. E. T. Gauvreau, aged 75, died at his home in Superior, January 12, following a six months' illness. Doctor Gauvreau was born in Quebec, Canada, where he was reared and received his education, graduating from Laval University. He was married in that city to Miss Marie Dechance, then settled in Calais, Maine, where he practiced his profession for a number of years. In 1881 Doctor Gauvreau came to the head of the lakes and settled in Superior where he has resided ever since. Doctor Gauvreau was a charter member of the Douglas County Medical Society and was influential in locating St. Francis Hospital at Superior. Doctors C. S. Knox, J. C. Adams, H. A. Russell, F. C. Sarazin, P. G. McGill, T. J. O'Leary, acted as pall bearers and interment was made in St. Francis cemetery.

Dr. Theodore W. Evans died at his home in Madison, Wisconsin, at the age of 74, Monday, January 26. Doctor Evans had practiced his profession in Madison for forty years. During the Civil War he served in the First Wisconsin Regiment. He was a graduate of the University of Michigan.

Doctor Dwight Freeman of Topeka, Kansas, formerly a practitioner in Madison, Wisconsin, died at his home in Topeka recently.

It is related by Galen that a certain man who bathed himself in a bath heated by a fire of wood cut in a cave where serpents were, died incontinent, after coming out of the bath, for that the vapor of the wood with which the bath was heated was infected of poison.

—Petrus d' Apono, De Venena.

Samuel Gompers says: "There are still many to whom this world cataclysm has so little meaning that they are still pursuing luxuries and self-indulgence." Are you one of these people, or do you save to the utmost of your ability and with your savings buy War Savings Stamps?

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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The report from the state laboratory of hygiene and the other state laboratories presents many interesting features all of which are present in the tables which are given below. One point which has pleased me particularly, and one which I was rather surprised to find, that the studying the records shows, is that in spite of the absence of many doctors who regularly sent specimens to the laboratory, the unprecedented tax upon the remaining doctors because of the epidemic of influenza, and the absence of any epidemics of diphtheria, that we did a total of 7,256 diagnoses during the last six months in this laboratory alone, which indicates a falling off from the same period in 1917 of only 602 specimens.

Table I is a summary of the work done in the central laboratory, the State Laboratory of Hygiene. This table shows the total number of each kind of specimen and the total number of all kinds for the last six months. The table further shows what has been the result of each kind of diagnosis. Thus it is seen that we made 4,024 diphtheria diagnoses of which 2,953 were negative (—), 592 positive (+), 199 no growth (NG), 30 questionable (?), and 250 contaminated (C). The continuation of this table shows that of the 4,024 swabs received to be examined for diphtheria bacilli 2,185 were for diagnosis or from cases acutely sick at the time and 1,839 for release or from patients convalescing from diphtheria. It shows too that of the swabs sent for diagnosis, 2,185, 1,705 were negative (—), 212 positive (+), 97 contaminated (C), 141 no growth (NG), and 30 questionable (?); and of those sent for release, 1,839, 1,248 were negative (—), 380 positive (+), 153 contaminated (C), 58 no growth (NG).

I have mentioned in detail the report on the diphtheria to illustrate how our records are kept and to show how well the matter of securing negative cultures from cases which have had diphtheria is carried out before releasing the patient from isolation. The laboratory has been trying to impress the importance of the release cultures by sending a circular letter to each physician who failed to

send release cultures within one week after we had given him a positive diphtheria diagnosis.

After the State Cooperative Laboratories and the State Branch Laboratory began operation it was seen that it would be necessary to centralize all the data collected in these laboratories in one place and the records so kept that they would be available to the deputy health officers and others doing the epidemiological work for the State Board of Health. It was therefore decided to have them send each week all their data to the central laboratory to be arranged and filed as is the data obtained in this laboratory. I therefore have all the data from all the laboratories in the State which are under my supervision, and have been able in this report to furnish a detailed report from each one the same as from the central laboratory.

Thus it is seen that Tables II, III and IV give the same detailed report from the Rhinelander, Oshkosh and Kenosha laboratories as is presented from the State Laboratory of Hygiene called the central laboratory.

Table V is a summary of the work done in all of our laboratories and gives the total number of diagnoses done in the State. It is seen that in all the laboratories there was made a total of 9,417 diagnoses.

Table I. Summary of data from the State Laboratory of Hygiene July 1, 1918, to January 1, 1919:

Diphtheria	2953—	592+	199NG	30?	250C.	4024
Typhoid	262—	34+	2 Us.	47?		345
Paratyphoid	343—		2 Us.			345
Sputum	1044—	454+	2 Us.			1500
Rabies	13—	8+				21
Water	191—	107+	73Fe	24?	8C. 2 Alk.	
	3 Uns.	6 Chem.	37 Special			451
Gonorrhea	89—	57+2?	7 Us.			155
Miscellaneous						241
Not examined						174
						7256

Number of doses of typhoid vaccine	1320
Number of doses of paratyphoid vaccine	15
Number of doses of triple vaccine	744
Number of c.c. of pneumococcus vaccine	780
Number of sputum containers	1713
Number of diphtheria containers	2216
Number of gonorrhea containers	34
Number of doctors and health officers sending specimens	782
Number of cities sending specimens	375

Swabs for diagnosis	1705—	212+	97C.	141NG	30?
Swabs for release	1248—	380—	153C.	58NG	

Table II. Summary of data from the Rhinelander Laboratory July 1, 1918, to January 1, 1919.

Diphtheria	581—	120+	9C	2NG	712
Typhoid	19—	5+			24
Paratyphoid	23—				23
Sputum	185—	59+			244
Water	24—	11+	2?	1C	38
Gonorrhea	22—	9+	1?		32
Miscellaneous					56
					1129

Swabs for diagnosis	57+	2NG	155—	5C.
Swabs for release	63+		426—	4C.

Table III. Summary of data from the Oshkosh Laboratory July 22, 1918, to January 1, 1919.

Diphtheria	26—	9+		35
Typhoid	18—	4+	1?	23
Paratyphoid	3—			3
Sputum	53—	50+		103
Water	49—	46+	1C.	96
Gonorrhea	12—	17+		29
Miscellaneous				82
				371

Swabs for diagnosis	5+	19—
Swabs for release	4+	7—

Table IV. Summary of data from the Kenosha Laboratory August 13, 1918, to January 1, 1919.

Diphtheria	411—	20+	2ND	433
Typhoid	3—	1+		4
Paratyphoid	1—			1
Sputum	62—	30+	1ND	93
Water	2—	1+	1?	4
Gonorrhea	11—	6+		17
Miscellaneous				109
				661

Swabs for diagnosis	12+	213—	
Swabs for release	8+	198—	2ND

Table V. Summary of data from the Central and Branch Laboratories.

Diphtheria	3971—	741+	30?	259C.	201NG	2ND 5204
Typhoid	302—	44+	48?	2 Us.		396
Paratyphoid	370—			2 Us.		372
Sputum	1344—	593+		2 Us.	1ND	1940
Rabies	13—	8+				21
	3 Us.	6 Chem.	37 Special			589
Gonorrhea	134—	89+	3?	7 Us.		233
Miscellaneous						488
Not examined						174
Total						9417

Swabs for diagnosis	2092—	286+	143NG	102C.	30?
Swabs for release	1879—	455+	58NG	157C.	2ND

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TO EXTEND SANATORIUM SERVICE.

A long step forward in the management of the county tuberculosis sanatoria of Wisconsin was taken during the month of January when a representative body of county board supervisors, sanatorium trustees, medical directors and superintendents met in conference at Milwaukee to discuss legislation needed to insure and increase the efficiency of the institutions. It was the first conference of the kind ever held in the state and the earnestness and the keen interest with which the men and women present received various practical suggestions for extending the service of the sanatorium were most significant.

The conference was called by the Wisconsin Anti-Tuberculosis Association which in the past has assumed the responsibility of securing from the legislature the biennial appropriation for state and to county sanatoria and such other legislation as seemed urgent. With the growing number of county institutions, it was felt that the time had come for the several boards of trustees to share in this responsibility. Beyond this actuating impulse, however, there was the larger purpose of stimulating a broader view of the responsibilities of sanatorium management by the interchange of views and suggestions.

The direct outcome of the conference was the appointment of a legislative committee with specific instructions along several definite and constructive lines, the election of Dr. G. Windesheim of Kenosha as permanent chairman, and the decision to hold similar conferences once or twice each year. The personnel of the committee on legislation is H. E. Marquardt, Marathon County; F. F. Kress, Brown County; A. S. Titus, Racine County; C. R. Thompson, La Crosse County; and Dr. H. G. Nixon, Waukesha County, with T. J. Werle of the Wisconsin Anti-Tuberculosis Association as an ex-officio member of the committee.

Owing to increased maintenance costs, it was unanimously decided to ask for an appropriation large enough to raise the amount of state aid to seven dollars ($7.00) a week instead of five ($5.00) as has been the custom in the past. The conference also went on record as favoring legislation authorizing county sanatoria to establish out-patient departments with visiting nurse service in the homes and occupational therapy departments under the direction of a trained supervisor. A plan for establishing the work in several of the smaller institutions under one itinerant occupational director, proposed by Dr. H. E. Dearholt, points the way to a speedier adoption of this new therapeutic force than would be possible if it were left entirely to the initiative of the individual institution.

ABSTRACTS

THE GAUZE FACE MASK. D. A. Haller (Pocahontas, Va.), and R. C. Colwell, Camp Grant, Rockford, Ill. (*Journal A. M. A.*, Oct. 12, 1918), report experimental studies made as to the efficiency of the gauze face mask in protecting from bacillary infection. The masks used in the hospital at Camp Grant came from different sources, and showed great variations in the number of layers of gauze and the quality of the material. They varied in size also and in some cases were too small. A great difference was noticed before and after washing. One of the authors was found to be a badly infected carrier of typical Type IV pneumococci and the experiments were made by coughing directly at a Petri dish containing human blood agar medium, first without a mask and later with masks over the face. The number of colonies coughed through the different masks was noted and the masks compared. The tests had to be made at single sittings with a complete series of the masks, as the contamination of the mouth was not at all the same at different times. The details of the experiments are related and the conclusion reached is that the amount of gauze placed in superimposed layers needed to give complete protection when the mask is worn over the face of the infected person is very close to the equivalent of 300 strands of cotton fibre to the square inch. The authors experimented also to see whether the filtration was as complete after the mask had been worn some time as when first put on. It was shown that no more organisms penetrate the mask after thirty minutes use than when it is first applied to the face, but if dried and reversed it becomes not a filter but a disseminator of organisms. The practice of marking the face side of the mask by a small strand of black thread is a good one, and should be followed in all cases. Another series of experiments was made to determine how many superimposed layers of gauze are necessary to protect when applied over the face of the uninfected, and it was found that five layers were necessary. A third series of tests were made with duplicate masks, one over the face and one over the exposed Petri dish. It was found that the mask over the face of the infected is of value in the protection of the uninfected. Work with reknit gauze has shown that it is almost impossible to estimate its efficiency because of its remarkable stretching. A small amount of work was done with Turkish toweling and tended to show that one layer of this material makes a highly efficient droplet filter. Expense has to be considered, however, in this matter. The article ends with suggestions as to masks that have been deduced from their experience and experiments.

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ORIGINAL ARTICLES

HOSPITAL STANDARDIZATION.*

BY J. M. DODD, M. D., F. A. C. S.,

ASHLAND.

The importance of the hospital as a public utility and a public benefaction has grown steadily in favor for the past quarter of a century, and commands our especial attention now under the prominence given it by the conditions due to the war and the reconstruction period that is to follow it.

Hospitals have grown in numbers and efficiency, keeping pace with the rapid advances of medicine and surgery, and have become a recognized public need supported by an appreciative public. It is not the abode of pain and suffering as some suppose, for there is very little suffering in a well conducted hospital, and it is seldom now that we encounter the dread of the hospital that existed a few years ago.

The hospital is a workshop where the doctor does his expert work, and all expert craftsmen do their best work in a shop properly equipped for all varieties of work to be undertaken. Not all hospitals are properly equipped, and not all the work in them is done by expert workmen. Sometimes the fault is with the hospital, but too often it is due to incapacity and lack of training of the workmen. Not infrequently the blame belongs to both in their mutual effort to protect each other. In these days of scientific progress few of us are doing our work so well but that it might be improved. The movement of standardization of the hospitals is an effort to improve the service in these institutions and to bring their work in conformity with a set of standards that will result in better equipment, better management, better work, better records for future reference, and consequently better service to humanity.

A generation has seen the hospital grow from an almshouse to a palace equipped with every device that ingenuity could devise for the relief of suffering humanity and available to rich and poor alike, but there is still much to be desired in the manner which these institutions are conducted and the work in them is done.

In my effort to cover the subject of hospital standardization within the limits of a short paper, I am admonished that I have entered a rather large field, and that what I shall say must be chiefly fundamental, but I hope that what I may say will bring about a discussion of many points I know are uppermost in the minds of my hearers, and as progress in Medical science must henceforth be dependent on the hospital more than any other agency it deserves our best consideration.

Much work has been done of late by the American Hospital Association, the Catholic Hospital Association, the Modern Hospital, the A. M. A. and the College of Surgeons, all tending to bring about a better understanding of our hospital problem, and a great good has been accomplished through the efforts of these organizations. Theorizing and analyzing will not accomplish anything without practical application of the deduction of the analysis, and words are of no value unless material improvement follows.

The hospital of today cannot be a success unless its ideals are the greatest possible service to those entrusted to its care and the attainment of this object can only be determined by popular approval and careful and impartial analysis of results.

Hospital betterment must come through the medical profession because they alone know what hospital service should be, but doctors are inclined to leave this work to a limited few who are making a study of the subject or are actually engaged in hospital management.

The increase in number of hospitals has been a factor in improving their quality for it seems that in this as in other lines of activity, competition brings better service.

Physicians and surgeons must be awakened to

*Read at the 72nd Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, Oct. 4, 1918.

their duty in this regard, but before pointing the way to others, they must themselves prove their ability to continue in it.

Wisconsin stands high in hospital ideals and practice among the states of the Union as she does in the public health and other activities of the medical profession and a brief survey of the hospitals seems fitting at this time.

In 1908 there were in Wisconsin 76 hospitals aside from the asylums and sanitariums, with a total of 3380 beds. There are now, ten years later, 109 hospitals with an aggregate of 5375 beds, an increase in this period of 33 hospitals and 1995 beds. The proportion of the hospital beds then was 1 to 651, now it is 1 to 479.

There are in these hospitals 32 accredited training schools for nurses with 800 nurses in training. There are only 26 internes in all the hospitals of the state, according to a survey recently made by the College of Surgeons. These hospitals serve a medical population of 2817 physicians and surgeons.

As to ownership: 60 hospitals are owned by individuals, doctors and others, 35 are Catholic, 6 are city or county, 2 are owned by associations and 5 are Lutheran. There are a number of homes and sanitariums that have hospital aids, but these are not counted.

There are 53 having 30 or more beds—the minimum requirement, for a training school, of the Committee of Nurses of the State Board of Medical Examiners. The classification as to number of beds is as follows:

200 to 300	150 to 200	100 to 150	90 to 100	80 to 90	70 to 80	60 to 70	50 to 60	40 to 50	30 to 40	20 to 30	10 to 20	10 & less
3	4	13	1	2	2	6	7	4	11	19	30	1

There appears to be three classes of hospitals. The large public institution supported by the public treasury and conducted as a public utility; the hospital conducted by the religious orders supported by their earnings and the contributions of the charitably inclined; the third class owned and conducted by individuals or associations formed for the purpose, depending for revenue on the earnings of the hospital.

The first class is subject to the vagaries of politics, the second is under the restrictions of creed and finds some difficulty in conforming to the requirements of modern science, and the third represents individual interests, community needs or professional ideals. They are the smaller hospitals and are likely to lack in equipment and scientific management.

All of them, with the exception of some regulations by the State Board of Health, are left to pursue a course as dictated by their own consciences, and are accepted by the public at the rating they have arbitrarily set for themselves.

Progress is slow especially in institutions which have been permitted to establish their own ideals and to continue long in the exercise of what they have learned to regard as their unquestionable rights.

In the Hospital problem today, the greatest need is not the building, not the equipment, but the service. Building, equipment, financial and general management are essentials but the finest set of tools in the world are useless in the hands of a bungling, incompetent workman. The expert will often do good work with very poor equipment. It will be remembered that Joseph Price said he could do the very best surgery with an ironing board for a table, a teakettle for boiling water and a dish pan for his instruments. I once visited his hospital, conducted in a primitive way, and he was getting as good results as other surgeons, but he was a genius whom all of us could not follow. Many of us recall much good surgical work we have done in the kitchen of a dwelling house, but all prefer the equipment and conveniences of a modern operating room, where the details of sterilization and cleanliness are worked out, and where plenty of assistance is available.

One of the crying needs is for the public to know what a hospital should be, and the people who must go to the hospital for treatment have no means of knowing the quality of service they receive any more than they know whether or not their doctor is giving the best service obtainable. If they are pleased, that seems to be the only proof required.

We wonder if the time is not coming when the doctors and hospitals will be required to answer to some tribunal in this world, as to the quality of their work. Here is a fertile field of opportunity for the medical profession in education of the public. It is apart from my purpose to discuss hospital management. Assuming these to be what they should be, let us consider the medical service, first in relation to the staff.

STAFF.

In most hospitals no restriction is made as to the qualification of doctors who practice in them—a diploma and license being considered ample proof as to moral and professional fitness.

It is one of the privileges of the medical profession that the doctor so long as he keeps within the limits of the law, and these limits are not clearly defined, may practice as he pleases, accountable to no one but his own conscience.

It is to the credit of the doctor that he has generally proved worthy of the trust, though it is possible that if his work were subjected to the scrutiny of a competent and impartial judge, the seal of approval would not always be put upon it.

It is not for the best interests of all concerned that doctors and hospitals are not accountable to some one, and the time is coming when the system of inspection and supervision of work will be established in hospitals, and those who manage them, and are entrusted with human life in them, will have to qualify for such work by special instruction and training, and practitioners who treat patients within their walls will first have to establish their fitness so to do in some other way than by the means provided up to this time.

By the staff is understood the doctors who practice in the hospital. In few of our hospitals do we find an organized staff of specialists such as can work in harmony—which is the ideal staff. In nearly all hospitals, doctors take care of their own patients referring them to specialists only when something unusually technical is required. Among these there is little co-operation though the interests of all would be better served if there were. The lack of professional harmony is all too prevalent among us in spite of the efforts that have been put forth to convert the profession to the modern ethical ideals, and in this we are better than we were in the recent past. Much splendid work is being done in the hospitals of Wisconsin, and it is not all done in the large institutions. Some poor work is being done by incompetent hands, but taking it all in all, the work in our hospitals is to the credit of the profession.

We may pause a moment to analyze the lack of harmony in our profession. It exists and probably always will, for no one can interpret the mind of his fellow nor read the motives for his acts, and no one has time or inclination to explain himself fully to every one he meets. The individuals of the profession work not for themselves, and their achievements are common property. There will always be some who are willing to spend their lives working for the common good, and there are always others who are willing to take a share in the product they did not help to produce, and human nature is much the same throughout the ages, and in all professions.

In medicine, as in every line of human endeavor there can be no progress except in service. Every successful enterprise must depend for its success on its measure of usefulness to the human family. Therefore the highest ideals in the medical profession will always be in the majority among those who see in their professional work the real call to service rather than an opportunity for material and personal gain. There will always be the honest doctor who will get the best possible service for his patients regardless of his own interests. Of such should the staff of the hospital be composed.

There should be a chief who has authority to assign patients who come promiscuously, to those best qualified to treat them, and as near as possible should maintain a harmonious co-operation. If there be no chief of staff, the hospital superintendent should exercise this function and assign patients to doctors who have demonstrated ability in special lines always keeping in mind the best interests of the patient. The practice of assigning patients to the doctor, who belongs to the same church or lodge as the patient, is found to exist, and needs to be curbed. Church, creed or personal friendship should not stand in the way of best medical service.

Every man, woman and child who applies for admission to the hospital has the right to a thorough examination, and a diagnosis arrived at after a careful examination and analysis of history and symptoms and then be treated accordingly.

Records of large well conducted hospitals show a large percentage of wrong diagnosis at autopsy, and how far we must depart from the right diagnostic path in our hastily made diagnosis and slip shod prescribing no one knows. Nature is kind and often cures where we have failed through wrong diagnosis and therapy.

After all, when we come to think that in medical or hospital work we are clothed with the functions of judge and jury, we fear the danger of becoming unwittingly the executioner.

LABORATORY.

Every hospital should have at its command a good laboratory. It should be in the hospital, and if not, it should be conveniently located so as to be readily accessible for aid in diagnostic work.

Today there is a scarcity of all kinds of hospital help, and the rarest of all is the competent laboratory technician. Laboratory reports as sometimes put up to us by incompetent and unreliable technicians is one of the evils we have to guard against, for laboratory findings are worse than valueless if incorrect.

There is not a more promising field for professional people than the laboratory, and yet it seems to be the hardest kind of work to get people to take it up. Special courses are being provided in the colleges, but there is danger of attempting to train within too short a time people who are deficient in preliminary education in chemistry and bacteriology and here as elsewhere a little knowledge is dangerous.

I have had personal experience in attempting to keep competent people in my laboratory and the demand indicates that others are having the same trouble. There is a great demand for these expert people, and they command higher salaries than the average clinical group can afford. In this as in many other activities, we may have to mark time until the war is over, and then no doubt there will be plenty of people who will take to this kind of work.

Every doctor who has had a good laboratory to help make, and to check up, diagnosis knows what a comfort it is to have the laboratory confirm the diagnosis, or clear up for us some question of doubt.

THE X-RAY LABORATORY.

No well equipped hospital today is without an X-ray laboratory, and its need is so fundamental that it scarcely seems necessary to mention it.

It should, however, be in the hands of a competent operator who has been specially trained in the taking and interpretation of skiagraphs.

The skiagraph can be one of our best aids, and again it can be made an instrument of deception as all readily believe who have seen pictures that had been taken in certain positions, and under certain conditions.

Here, as elsewhere, honesty and efficiency are prerequisites.

INTERNES.

Every hospital of 30 beds or more should have an interne, and an additional one for each 30 to 50 patients. This on account of the advantage to the patient to have a doctor on hand at all times for emergencies, and to aid in carrying out the therapeutic measures ordered by the attending doctor, but for the far more important reason that the interne year is the best part of the doctor's education. Here he is brought into intimate practical contact with the work he has been learning, and he goes forth on his medical mission infinitely better equipped than he could possibly be without this practical training.

All this preparation and accumulation of theoretical and practical knowledge reverts to the advantage of mankind, for anything that makes better doctors lessens suffering and prolongs human life.

The interneship is the modern successor to the practical experience under a preceptor which was the order a generation ago, and was the most valuable training then extant. A rather extensive experience with men just out of school, and who have taken interneships under my observation has impressed me that as many as possible of our doctors should have the interne year, but this year should be made as valuable as possible to him in a professional way, and he should be compensated financially.

Few students—after the expense of a preliminary and professional education can afford to spend a year in a hospital without pay, and I maintain that the interne should be paid a salary in addition to his living expenses. The amount of this salary must be left to the hospitals, but it impresses me that it should be at least $50.00 per month. It is commonly agreed that the interne should not be an orderly, and that he should have access to a good library and be provided with a good working clinical equipment. The staff should see to it that he has every advantage of observation and participation in treatment under their direction.

NURSES.

It is well recognized that nursing has made the hospital popular. Without nurses the hospital could not exist and surgery would be an undeveloped art. By using the hospital as a training

school for nurses a class of most useful people is developed, and no greater boon has come to humanity than the trained nurse.

Nurses, like doctors, must be systematically educated and trained, and the schools must conform to some acceptable plan so that a standard may be set and maintained. Registration is provided for those who have acceptably qualified themselves and a nurse with R. N. after her name has given proof that she is entitled to the trust and confidence of the medical profession and the public.

Legislation in Wisconsin for the registration of nurses was begun in 1911 and in 1912. The administration of the provesions of the law was placed in the hands of a committee of five appointed by and under the jurisdiction of the State Board of Medical Examiners in 1915, with which Board the Committee has worked harmoniously and effectively to the present time.

There have been registered in Wisconsin up to this time 1863 nurses. Inspections of hospitals and training schools have been made and a curriculum for training schools worked out in accordance with the most approved methods of nursing education.

The Committee rules that only hospitals of 30 beds or more with a minimum daily average of 20 patients can give adequate training to nurses, and the difficulties which have arisen in the enforcement of this rule have been in hospitals near this border line. Some of the hospitals have resented the effort of the Committee to enforce its requirements but in the main have complied when the real purpose of nursing legislation was understood by them.

The small hospital has much in its favor as it indicates a desire on the part of the doctor to give his patients the best possible service, and this he cannot do by treating them in their own homes. There are very few homes that have the necessary facilities for caring for the sick even with the services of a trained nurse, besides it is a matter of common observation that patients seldom do well in the environment of their own homes. Much ill bestowed sentiment has been wasted in this way especially in regard to children who make good hospital patients when parents can be induced to leave them to the care of the hospital.

On the other hand, the smaller hospital is likely to lack in equipment and facilities for treatment that are found in larger and easily accessible institutions. I would not discourage the small hospital but would insist that it have trained nurses, that it be conducted in the same systematic way as the large hospital, and not undertake work it is not qualified to do. They can do a great good in rural communities or places remote from the medical centers, and I have seen it demonstrated that the small hospital properly conducted can be made self-supporting in a financial way.

It is evident that something will have to be done relative to the training of nurses in these hospitals. Doctors who are conducting schools in hospitals of less than 30 beds are demanding recognition for their nurses. There are in the state 56 hospitals having less than 30 beds, so this is likely to become an active question soon. It is within the range of possibility that a system of affiliation will be established in making it possible for these smaller schools to obtain recognition. It is to be hoped that this will be brought about, for many of these hospitals are giving excellent training, and in many instances making better nurses than the large hospitals. In this as in every line of progress, there is much to be seen ahead. These small hospitals are the product of a need felt by the doctors in rural communities where distances are great and long drives necessary, for a place where a limited number of patients may be cared for, and given closer supervision and better treatment than they could get at home, and they must have nurses. In a way, this is a conservation of energy for a nurse can take care of several cases, if they are grouped together, and the doctor can also take care of more patients. This is an important consideration during the period of war as doctors and nurses are below the minimum requirements of the civilian population, and the people must look to the hospitals for a greater part of their medical service. There is a sort of group psychology in the hospital and patients help each other. They also compare notes on the doctor and keep him from becoming careless.

Several suggestions have been made as to plans whereby the number of nurses may be hurriedly increased to meet the demands of the war. None have seemed to meet it so well as the recent drive for student nurses which resulted in a large number of young women enlisted for this service. The enthusiasm of enlisting for war work induced many to enter, who would not have done so otherwise. These student nurses are to be sent into

army and civilian hospitals for training. This is an excellent plan and is only the continuation of the work started by the Nurses' Association and other agencies several months ago with the purpose of having all hospitals of the state increase their number of nurses to full capacity. I have felt that it would be a good plan to meet the emergency by sending nurses into war work at the end of their second year, their diplomas to be withheld until they had served the third year to the satisfaction of their school. This would release a large number of nurses and would be a valuable war measure.

The Red Cross Nursing service has been recruited from Wisconsin during 1917 and this far in 1918 to the number of 540, and these splendid women are doing their part in the great world struggle.

ANAESTHETIST.

It has become the practice in many hospitals to have a specially trained nurse as anaesthetist and while objection has been raised to this on the ground that the giving of an anaesthetic is a major medical procedure, and should only be undertaken by one who has full medical training, the nurse anaesthetist has become fairly well established. Few doctors care to give anaesthetics, and few can do so as a part of a general practice. It is not practicable for them to specialize in this line except in the large medical centers. A doctor cannot very well combine this specialty with a general practice for he should be available at all times for operative work.

Nurses appear to make the best anaesthetists. They are reliable and attentive to their work, and they possess qualities of manner that at once secure the confidence and trust of the patient, which is the first and most important stage of anaesthesia. Our state has ruled that the nurse may give the anaesthetic just the same as she would administer a medicine in any other way, and that the surgeon in charge of the patient is responsible for her work.

Now as to the part to be taken by the Wisconsin hospitals in the war.

There were 2,000 drafted men in the first draft with remediable defects and surgeons and hospitals were given an opportunity to give their services to these men who desire to be fitted for military service.

The surgeons generally offered their services, and the hospitals offered to furnish hospital service at actual cost, and County Councils of Defense were asked to provide funds for this purpose. Many of the men are patriotic enough to pay at least for the hospital care. Some have the nerve to accept the gratuituous service of the surgeon, and engage and pay for the best room in the hospital. Very few but who can pay for necessary hospital care without calling on the Council of Defense, and it is a test of their patriotism that they do what they can to fit themselves for military service without expense to the Government. This work is scattered over the state, and can be done without subjecting surgeons to much expense and inconvenience, and they can do this among the many other things they are cheerfully doing to help win the war.

Many of our hospitals will no doubt be called upon to take care of the returning soldiers, and on this account as well as the probability of increased civilian needs, the hospitals should be brought to and kept at the highest degree of efficiency consistent with the scarcity of doctors and nurses. The Government encourages the building and maintenance of hospitals, recognizing them as one of the greatest public assets.

In conclusion let us remember that progress toward our ideals is slow and papers like this become a mass of meaningless words if some action does not follow to reduce our theory to practice. Our hospitals can be made better and the doctors must lead the way. We can begin by demanding intelligence and efficiency in the management of the hospital. There are ways in which this demand can be enforced though it may have to be done indirectly and some people are not easily educated. The patient must have a reception suited to his or her temperament and needs, followed by a carefully written history, a thorough examination, specific directions as to treatment written down for the guidance of the nurse and then be put to bed, and made comfortable and to feel at home, and as the case progresses a clinical history should be carefully kept that end results may be determined. Emergency cases will require temporary relief while the ceremonies of his admission are in progress. It may seem superfluous to mention details so well known to all, but it does no harm to remind ourselves occasionally of elementary things. Intelligence, painstaking care, honesty of purpose

and fidelity to the great trust reposed in us must actuate both doctor and hospital or standardization of the hospital will accomplish little good, and we shall be found wanting in the great work so vitally dependent on the medical profession and all its allied agencies of which the hospital is one of the greatest.

DISCUSSION.

PRESIDENT: This paper by Dr. Dodd is now open for general discussion.

DR. HOYT E. DEARHOLT, Milwaukee: Mr. Chairman and Gentlemen. As I listened to Dr. Dodd's paper I thought of saying something that he touched upon in his conclusion. My thought was this: this paper will not have been worth the writing if its message is given only to those of us who are here this morning. We, probably less than almost anybody, need it to hear what he has said. I consider it a most excellent paper, and the right paper delivered in the wrong place. I do not mean by that to detract from the reading here, but the real purpose of that paper should be to open the eyes of the people who do not know these conditions as well as Dr. Dodd and the other physicians who are here present know them. I should like to commend this paper to the consideration of our Committee on Health and Public Instruction, with the thought that they may secure reprints of it and distribute it among hospital boards of trustees, public officials, philanthropists, and that class of people who, in the final analysis are responsible for the bad conditions in hospitals.

In the management of hospitals, training schools for nurses and kindred matters, we physicians have done what we used to do in all lines of social medicine, and that is, to take altogether too much responsibility upon our own shoulders. We have carried that responsibility without complaint, and without asking other people who had the power to correct the conditions, to carry their end of the load. Take the matter of hospital training schools. We know that in the past there has been a tremendous amount of exploitation of the women who have carried on the service burden of hospitals; we know that it is a question whether or not three years are ever required for their education—at least education of the character which they receive; and yet we have kept them in the hospitals. And why? Because we needed the service. We did not start out deliberately to exploit this class of women, but we had a great big obligation to keep the hospitals going, and to render the service that could be rendered to the public. The public did not understand, and we did not make the public understand how much we were attempting to do that we should not have attempted to do. We should have said to the public directly, this hospital cannot be run at the price that we are charging for accommodations, or that we are permitting the boards of trustees to charge for the accommodations; you are getting more than you pay for; somebody is rendering charity. The nurses have been rendering too much charity; the doctors have, and the interns. The benefits of the hospital come ultimately to the users of it, as Dr. Dodd has said, and the users of it, one way or another, should be made to pay. Now unfortunately this touches the discussions which are coming up later on in the morning. When people are sick they are least able to pay, and that is why some of us feel that the state, and the public generally, philanthropists, etc., must share in this burden out of their abundant means to do so.

As I said at the beginning, I should like to see this paper given very general publicity among the people who need the information most, and who have the power to correct and improve many of the conditions to accord with the splendid ideals that Dr. Dodd has set forth.

If it is in order, Mr. President, I would introduce a resolution commending an arrangement whereby the ideals of Dr. Dodd's paper will be printed and circulated where it will do the most good for the public.

PRESIDENT: Who will you leave that matter to, Doctor? Who will it be referred to?

DR. DEARHOLT: The Committee on Public Information.

PRESIDENT: The Publication Committee or the Committee on Public Health and Instruction?

DR. S. S. HALL, Ripon: On Public Education.

PRESIDENT: There are two committees that this matter can be referred to. One is the Committee on Health and Public Instruction, and the other is the Committee on Publication.

DR. DEARHOLT: I should suggest the Committee on Health and Public Instruction.

PRESIDENT: The Committee on Health and Public Instruction. Is there any second to this motion?

Motion seconded.

PRESIDENT: Are there further remarks or discussion on the paper, or will you act on the motion first. Are there remarks on this motion? If not, all in favor will signify by saying "aye"; opposed "no."

Motion unanimously carried.

PRESIDENT: Are there further remarks or discussion on the paper of Dr. Dodd?

DR. L. F. JERMAIN, Milwaukee: Mr. President and Gentlemen. At a time like this, when thousands of our boys are going to come back maimed and ill, and at a time when there is such a scarcity of medical men and nurses in civilian communities, a paper like this is surely in place.

The medical profession in a measure is going to be held responsible for conditions in the hospitals. The medical profession must see to it that the hospitals that our boys enter when they come back are such as permit of the most up-to-date and scientific diagnosis and treatment. Growth and development, and the increase in the number of hospitals should be encouraged. There is no question but what, in the state of Wisconsin particu-

larly, we are short of hospitals. That condition is probably more apparent in the larger cities even than in the smaller towns. In Milwaukee today we have this situation: every hospital is full; there isn't a bed to be had in a Milwaukee hospital; yesterday afternoon a few of the boys in the Students Army Training Corps became ill with influenza; I telephoned to every hospital in Milwaukee, and I could not find a bed in a hospital. Now something must be done to remedy this condition.

However, great as is the need for more hospitals, I think the need for better hospitals is very much greater, and, as Dr. Dodd has said, it is the business of the medical profession to see to it that the hospitals are brought up to a high standard of equipment, and that an effort be made to get the right kind of staffs to do the right kind of work.

I am the last one to decry or to oppose the opening up of small hospitals in smaller communities, because I think after all no matter how poorly equipped they are, they are perhaps doing better work than could be done in the homes, and especially at this time, when our civilian population is going to be forced into the hospitals to a much greater degree than ever before. But if a man has sufficient money to open a hospital and does open one, and has sufficient money to run it and furnish it as a hospital, he surely has money enough to put in the necessary equipment to do at least the necessary things in ordinary diagnosis. I have seen hospitals in the state of Wisconsin which, if you turned them inside out, would not be found to contain a half a dozen test tubes in the whole building. Now what kind of work can a man do in such a place? And those were not emergency hospitals. They were hospitals in which major medical and surgical work was being done all the time. They were not places in which accidental cases and emergency cases were taken care of; they were hospitals in which major surgical work was being done, such as could be deferred, cases that should be carefully diagnosed, where there was plenty of time to make a diagnosis. If a man breaks a leg or has a skull fracture out in the country, it is perfectly proper to take him to a hospital and take care of him immediately, or take him anywhere and take care of him; but I think it is criminal for any man to open an abdomen for a chronic condition in a place of that kind, without any means of making a careful examination, without any equipment for laboratory work.

Your Hospital Committee has had one meeting, and at that meeting a resolution was introduced and passed, to the effect that the State Board of Health of the state of Wisconsin ask the Legislative Committee of the State Medical Society formally to introduce a bill at the coming session of the Legislature licensing the hospitals in the state of Wisconsin. The state licenses its bakery-shops; it licenses its butcher-shops; it licenses its barber-shops; it licenses pretty nearly everything. But the hospital is conducted without any supervision, and without any restriction. Now why should not the hospitals be licensed? Why should there not be authority, either through the State Board of Medical Examiners, or through the State Board of Health to inspect hospitals and refuse them a license if they are not properly conducted.

Another resolution that was adopted by your Committee on Hospitals (with the idea of improving and correcting the situation as it is at present) was to the effect that in view of the interne situation in the state, the recommendation be that the fifth or hospital year be made compulsory in the state of Wisconsin. Marquette Medical School is ready at this time to make the fifth hospital year a compulsory year, the medical school withholding diplomas from medical students until the fifth or hospital year has been satisfactorily spent in a hospital which is deemed equipped in a manner to give the interne the proper training. Now it probably would be well, if that requirement were incorporated into the law, and made a requirement for practice in the state of Wisconsin, namely, that a man could not be licensed to practice medicine in the state of Wisconsin unless he has had a fifth, or hospital year, under proper supervision. This would relieve the situation in many ways. In the first place it would secure for the interne a hospital in which he can really spend his time to advantage; it will secure for the interne a hospital which is going to give him the best kind of training that he can get. In the second place, it will help out the hospital; because it will stop the migration of internes, and it will stop the interne's leaving in the middle of the year. At present, when the interne becomes dissatisfied for some reason or other, he will leave, or will find a more attractive position, leaving the hospital in the middle of his interneship, and the hospital is left without help. If the fifth year is made compulsory, the interne will have to stay as long as he is getting what is right. he has got to stay until that year is completed; otherwise he will not get his diploma.

These and many other questions are important at this time. I think, and I again want to emphasize what Dr. Dodd has said, that after all we say, and after all we do, the proposition comes back to the medical profession. We are responsible. I know this from personal experience, that no matter who your board of trustees may be, no matter who your Sisterhood in charge of the hospital, no matter what hospital you are working in, if the staff of that hospital is really in earnest, and if they know what they want, and actually make use of what they get, there will be little difficulty in getting what you want or need. The trouble is with the staff; a good staff is most essential; equipment does not amount to anything. I have seen hospitals where the equipment was lying around unused; that is not going to make a hospital; you cannot standardize a hospital by the equipment that they have in the hospital. It is the men who are working in the hospital, that make the hospital. If you get the right kind of a staff, one composed of men who are scientifically interested, who have the welfare of the patients at heart, you will find that those are the men who are going to do good work, and with a minimum amount of equipment.

Dr. George C. Ruhland, Milwaukee: I should like to add briefly a word or two on the matter of hospital standardization, in connection with the plea for inves-

tigating and licensing hospitals, which Dr. Jermain has referred to. So far as the lying-in hospitals are concerned, we have a definite hold on the situation, and have in this city closed up quite a number of the cheaper lying-in hospitals, or insisted upon correction and improvement in others; so we definitely have a hold on them, and all that we need to do is to extend the authority, and I think it would be wisdom to so extend it.

Another point which I should like to bring out is in connection with contagious diseases and general hospitals. Personally I think it is a big mistake that the general hospitals do not provide for the care of the contagious diseases that will every now and then develop in these institutions. Something should be done in that regard. It is exceedingly regrettable that in the city of Milwaukee, in the large hospitals that we have, there is no provision made in practically any of them, for the housing of a case of contagious disease when it does develop. This has resulted in the cases simply being turned into the corridor—a very objectionable practice.

Referring specifically to the matter of the staff that makes up your hospital, I should like to urge that the staff insist that both the members of the staff serving at the hospital, as well as the nurses, be made to live up to the best thought in preventive medicine. By that I mean that physicians, as well as nurses, be immunized against contagious and communicable diseases, such as typhoid fever, smallpox, and the like. I think it is an unpardonable reflection on the medical profession if the nurses in our institutions, and the physicians, come down with diseases that are preventable by proper immunization; and yet that happens every now and then. We know that it is not necessary. In the Milwaukee contagious hospital we immunize all of our nurses, and do so repeatedly, and with most satisfactory results.

These are points in hospital standardization which I think should be insisted upon. We can never persuade the public that we can prevent disease if the profession, supposedly best informed, does not live up to that thought in actual work.

CHAIRMAN: Is there further discussion of this paper?

DR. CHESTER M. ECHOLS, Milwaukee: I want to emphasize one point that Dr. Dodd made in his conclusion, and that is with reference to having a written history of every patient that enters the hospital. As far as I can determine by inquiry, even before the War, when internes were not so scarce as now, there were very few of the hospitals that insisted upon having complete written histories of the patients kept as part of the hospital records. Now that internes are very scarce, the problem is increasingly difficult. But there is a way in which we can increase the efficiency of our hospital work, without any additional equipment, without any further appropriations, without any greater number of nurses and internes, and without calling upon the public for help. I refer to a plan which we have adopted in one of the hospitals with which I am connected, of requiring every member of the staff, and every outside physician who is not on the staff, who brings a patient to that hospital for treatment, either medical, obstetrical or surgical, to write and furnish a complete history of that patient, which shall include the family history, the past history of the patient, a description of the present complaint of the patient, and a record of the present physical findings. That is a reasonable request to make of any man that expects to treat a patient in a hospital. The hospital furnishes us the necessary blanks, so that we can write the histories at our offices, if we prefer, and take them to the hospital and have them attached to the chart. I think it is a matter of common observation that failure to write complete histories of patients, such as I have described, is conducive to slovenly and unscientific work. The rule which we have adopted is rather stringent. It provides that if any member of the staff or any outside physician who treats a patient at that hospital and refuses to comply with this requirement, he is going to be denied the privilege of working in that hospital.

PRESIDENT: Is there further discussion of this paper?

REV. CHARLES B. MOULINIER, Milwaukee: Mr. Chairman, Ladies and Gentlemen. This is a subject in which I am deeply interested personally, and as connected with a medical school, and as working for the American College of Surgeons in the matter of hospital standardization.

The excellent paper of Dr. Dodd I think has covered every point involved in the subject.

With your permission, I should like to emphasize some of the things that are dominant in the mind of the American College of Surgeons. Everything is centered in the record. If you have but a proper record, one that is properly taken and properly kept, all the rest of your hospital work must be right. If your record room and your record-keeper is all that it and they should be, then your staff is what it should be, your laboratories are what they should be, your nurse's service to the patient is what it should be, because the record is nothing more than a statement of what has been done for the patient and with the patient from the moment of his entrance into the hospital. You will therefore, find in the records a history. And what scientific medical man today undertakes to treat a patient without a history? What scientific man undertakes to make a diagnosis without a physical examination, without applying all the tests, the laboratory test, including everything known to modern medicine? What careful medical man today will base a treatment, whether it be medical or operative, except on a thorough examination, involving everything that modern medicine knows? What conscientious and scientific medical man should be satisfied, after the treatment and the results of his treatment are beginning to show themselves, who does not secure, if possible, in case of death an autopsy, and in case of recovery a follow-up observation personally, through a nurse, through the Social Service Worker, or through a card sent to the individual? And all this means records. So that if one wants to estimate what a hospital is to-day, all he need do is ask, where is your record room, take me there and leave me alone for a while, and I can tell you in the course of half an hour or an hour what your hospital is, what it is doing, or

what it is not doing. Therefore, Gentlemen, the medical man is the one on whom the betterment of hospitals rests. Say what you will about the responsibility of the public, the response or co-operation that must come from the patient, from the nurse, it is the medical man who knows medical science, who must see to it that that medical science gets to the patient by way of diagnosis and of treatment. And your record is the written statement of what has been done, and what are the results of what has been done. There can be no adequate ser- there are medical men in it who know science, unless there are medical men in it who unselfishly give their service to every patient; unless there is group diagnosis and treatment in the hospitals.

Now in regard to just one or two other points, if you will pardon me. There should be in every hospital a designated, appointed and authorized record-keeper, one who has the full authority of the staff and the management to demand that the records be properly kept, properly handed in; that the histories be either made or vouched for by the members of the staff. You know that it takes a great deal of experience and skill to make a proper history. We are trying to teach our students how to take histories. We start with them in the sophomore year, and run with them in the junior year, and the senior year, and their hospital experience year, at the county, for instance, they go on with history taking; and yet, you all know, who have had experience, how easy it is for them to miss an essential point, and to put in a great deal that is irrelevant. History taking is a matter of keen mind, deep medical knowledge and experience. Therefore, every history, to be worth anything scientifically, must be either taken by, revised by and vouched for on the part of the member of the staff who has personal charge of the patient. Therefore, a record-keeper must be in the hospital who either has nothing else to do, or has that as a main function, a young man, a Sister, a clerk of any kind, who will not permit a patient to be in the house any length of time before the record is started, and will not permit that patient to leave the hospital until that record is finished to the point of follow-up and end result. There should be a committee in each hospital, if not an individual, who will see to it that autopsies are taken care of. What is this country ever going to come to in the way of advancing medical knowledge unless there is a systematic effort made all over the country to get more autopsies. You all know that there is where mistakes are discovered, where wrong diagnosis and faulty treatment are laid bare. You know that it is at the autopsy that the surgeon and the medical man and all find out whether they were correct in their diagnosis, whether they had made a sufficiently careful examination, had applied all the tests, and whether their conclusion was right or wrong. Therefore, unless as a medical profession throughout the country there grows a concerted effort to get autopsies, we are not going to make the progress that we should in medicine in this country. I hope some day, perhaps very far off it will be, to have some sort of a law, state or national, requiring autopsies in the case of those who have died from unknown causes, or unsatisfactorily known cause, or incompletely known cause. It looks like interfering with personal liberty, and there is a great deal of individual sentiment involved here. When there is a question of our own mother or father, or our own sister or brother, or our own relative or friend, an autopsy means a very different thing from what it does to the pauper, who seems to have no friend in the world. But that is all sentiment; I like to call it foolish sentiment; it is not looking to the welfare of the living, and that is what medicine is for, and that is what we are all aiming at, the welfare of the living. Consequently, there should be, and let us have it as a dominant characteristic of this state, a concerted effort to get all autopsies possible. We will have to begin persuasively; we will have to use the psychology of influence upon those concerned, those related to the sick, to secure it. I am told that at the Mayo clinic some 8 years ago they secured about 40 per cent of the autopsies upon those who died there, but by reason of a very carefully planned, gentle, well-thought-out procedure of dealing with the friends and relatives of those who had died, the percentage of autopsies secured there now is up near 90 per cent. And that same thing can be done today in all the hospitals, and it will be done there if the doctors and those in charge of the hospitals, and the nurses, begin to realize that it is in the autopsy and by the autopsy that medicine grows, that the service to the sick improves.

Technicians in laboratories. I should like to make a reference again that is personal, just because I think it is worth while for us in this state to know what is possible, and what has already begun. We have been giving at Marquette University Medical School a summer school for technicians. In two previous years we gave a six weeks course; this past year we gave a three months' course. We understand, of course, that that is the merest beginning. You must not expect, any of you, as you well know, that in a 3 months' course or a six weeks course continued for 3 years, 3 summers, is going to turn out a finished technician. They are mere beginners, just as the medical students when they finish school, are mere beginners. You must only think of them as persons prepared to start technician work in the hospital. And in the course of a year or two of daily experience in your hospitals, such a person, with the start acquired in the school, will become a satisfactory technician, and then the local pathologist, bacteriologist, and there must be some in nearly all cities of any size, will be the ones to train further this technician, to correct this technician, and to properly use the results of the work of that technician.

With these things cared for systematically all over the state there is every reason to believe that Wisconsin will grow rapidly in its development, and an ever and ever higher and higher scientific treatment of the sick, and that is what hospital standardization means—once more centering it all in the records, because if they are right, everything else must be right. I thank you.

CHAIRMAN: Is there further discussion of this paper?

Dr. Julius Noer, Stoughton: Mr. Chairman, Ladies and Gentlemen: A word regarding the small hospital in the small town. I think I am guilty of nearly all the crimes that the Marquette Medical School has denounced. I have done a lot of work in private houses that should not have been done, but I have been acting under the impulse that you should do what your conscience and your brain and your education tells you is the right thing to do for that patient at that place, with the facilities and opportunities that are at your disposal. The small town and the small hospital has been neglected, I think, by our leaders in the profession, and I think that has had a big influence upon my action. The city in which I live is a city of about 5000. We have two moderately large plants, one of them employing 350 to 400 men, and the other employing from 450 to 600 men. I have been a director in one of those companies for 18 years. I have been their surgeon for 26 or 27 years, and I have done a great deal of injury work during all of this time. You can see that we need a small hospital. We have one, or had one the last ten years, which is privately conducted; it is of course absolutely inadequately equipped; it does not pay as a financial proposition. I have twice turned down the proposition to organize a hospital in that city, because I was compelled to state that the proposition will not pay financially. It is very difficult the organize an institution in a small town and to be compelled to state in advance that it is not going to pay, and that somebody has got to pay the expenses. I think this matter needs special agitation. To my mind we are in very great need of a small hospital that is properly conducted, but how are we going to get it? You have got to educate the people to the need of that institution, and you have got to be educated to the idea that such an institution is not going to pay financial returns. The returns are simply going to be the return of the same kind that the health officer produces. The more efficiently the health officer does his work, the less need the public sees for the existence of that officer. I have come up against that condition repeatedly. The more efficiently and thoroughly I did my work, the less the city council would see the need of my doing that work. What are you going to do about it? It is simply a question, as has been suggested here by the Reverend gentleman who spoke, that we must educate the people. In that lies our hope for adequate hospital facilities for the small cities. And the big men in the profession—perhaps I should except men like the late Dr. Senn, and others who have said a good many good things about the work that is being done by the worker in the small town—ought not to merely content themselves by saying, he should not do it. I realize that, but there are things he must do; there is no way out of it; and he is doing it today as I am doing it, under especially difficult circumstances. We have not the laboratory facilities, and we cannot have them. I am a field man, I am not a laboratory man; I haven't the time, I haven't the training; I did have some training originally, but when you are out of that training you cannot pick up the matter easily as you go on; it needs experts to make all laboratory tests.

Dr. F. Gregory Connell, Oshkosh: Mr. President and Gentlemen: The hospital problem in Wisconsin is, I take it, but little different from the hospital problem in other states. Dr. Codman informs us there is a hospital problem in Massachusetts.

What is the matter with the hospital and why is there a hospital problem?

Much is being said about the hospital problem, and various methods of solution have been suggested, but it is rare that one hears, in words of one syllable, just what the problem is.

The hospitals have been accused of directing their energies toward the declaring of a dividend, or the diminution of a deficit, rather than to the securing of an improvement in service rendered and results achieved. The hospitals are interested in a low mortality rate, but show little concern regarding the morbidity.

The hospital problem is now exactly where the Medical School problem was ten years ago. A properly equipped and conducted medical school cannot exist as a financial enterprise today, the commercial medical school is a thing of past history.

The commercial hospital, that is, a boarding house for the sick, whether it be for the purpose of dividends, direct or indirect, is headed for the same grave in which it's kindred medical school has been safely buried.

Health is too sacred a thing to be trifled with for commercial advantage, and the hospital that does not show a financial deficit at the end of the year, to be made up by some means, has not performed its full limit of usefulness.

Something should be done to eliminate hospitals for revenue, and the times are most propitious for such measures. Federal control or regulation of hospitals may sound socialistic and may be objectionable, but if such control or regulation is advantageous and even necessary in financial matters such as banks, insurance companies, railroads, telephones, telegraph, etc., why will not the same advantage follow such control and regulation of the foundation of all health matters, the hospitals.

Secretary McAdoo said, "Our Merchant Fleet must be in the hands of an interest having boundless resources, an interest that is not compelled to concern itself with dividends to its stockholders or returns to its bond holders; an interest that can afford to suffer losses and sustain them for an indefinite period—namely, the Government." If this is true of our Merchant Fleet, it is certainly much more fitting when applied to our hospitals.

An initial step toward the raising of the standard of hospitals has been striven at in their registration, classification and inspection by the American College of Surgeons, in which Rev. Father Moulinier of your city has taken such an active and important part.

This is a beginning, and by moral force and persuasion has accomplished much and will accomplish much more; but in order to be of real accomplishment this work must have the authoritative stamp of legal

enactment. This will undoubtedly come, as soon as the lay people realize the problem—therefore, a campaign of publicity showing the difference between a commercial and scientific hospital. With the light of publicity thrown upon this difference, the desired result will follow automatically.

Codman Cards for End Results, with annual reports based upon these cards, will be a most simple manner of accomplishing this result; and because of the war, which is emphasizing the necessity of hospitals, and good hospitals, we may very soon expect legal regulations and requirements that will make the hospital a most unprofitable undertaking (financially speaking). Such a result will be one of the great benefits to partly compensate for this unspeakable war.

PRESIDENT: Although this is a very interesting discussion, and the subject should be thoroughly discussed, we have taken a little too much time, as we still have two other papers of general interest for this morning's session, so I will ask Dr. Dodd to close the discussion.

DR. J. M. DODD, Ashland: I will not prolong the discussion, Mr. President, I have nothing further to say.

PRESIDENT: The next paper on the program is an address on "Health Insurance," by Prof. J. R. Commons, of Madison.

Prof. J. R. Commons, University of Wisconsin, Madison, read a paper on "Health Insurance" as follows:

JOHN GRASPED THE IDEA.

From far Shanghai comes a storyette which would seem to point to the fact that John Chinaman, heathen as he is, has assimilated some western ideas on the virtues of the art of medicine.

"John," this particular specimen was asked, "do you have good doctors in China?"

"Good doctors!" he exclaimed. "China have best doctors in wo'ld."

"Hang Chang, over there, for instance. Do you call him a good doctor?"

"Hang Chang good doctor!" he exclaimed. "He glate! He save my life once!"

"You don't say so! How was that?"

"Me velly bad," he said confidentially. "Me callee Doctor Han Kou. Givee some medicine. Get velly, velly ill! Me callee Doctor San Sing. Givee more medicine. Me grow worse—going to die. Blimeby callee Doctor Hang Chang. He no got time; no come. He saved my life!"—*Ex.*

God will not ask from what college you are a graduate, what honorary degrees you have, what scientific discoveries you have made, what medals you have won. He will ask if you have tried to make your work, your profession, your world better. He will ask if you have worked with your Brother or against him.

MODERN TREATMENT OF RECTAL DISEASES.*

BY JEREMIAH DONOVAN, M. D.,

MILWAUKEE.

The hemorrhoid is taken as the type of disease forming the basis of this paper because what is true in the diagnosis and treatment of this pathological condition is equally true in the diagnosis and treatment of other rectal diseases.

In looking over the literature referring to hemorrhoids during recent years, one cannot help being impressed with the diversity of opinion that exists among surgeons as to the best method of treatment.

There is no doubt but that good results are at times obtained in carefully selected cases by the injection of phenol, but the danger accompanying this method of treatment, through inability to control sloughing and the danger of embolism is so great that it has been abandoned by proctologists, though still in vogue among advertising specialists.

Galvano-puncture, a process formerly having many advocates, consists in attaching a properly insulated needle to the negative pole, and plunging it deeply into the tumor and by means of the rheostat turning on sufficient current until the hemorrhoid assumes a dark color, showing decomposition of the blood, this in time to be taken up by the absorbents. Or a platinum needle, on the positive pole, introduced into the tumor with sufficient current turned on to produce a firm clot, also expected to be taken care of by the absorbents; in either case the current is completed by a large pad placed on the abdomen and connected to the opposite pole.

However it should not be forgotten that in these so-called "absorbent methods," so much advertised, the danger of sloughing from injections of carbolic acid is so great, there being no means by which the sloughing can be limited or controlled, the method cannot be too strongly condemned. The writer has seen in an Eastern clinic a patient so treated, by an advertising specialist, in whom the hand could easily be passed into the rectum and bladder through the sinus resulting from sloughing in this particular case from carbolic acid injection.

So, also, there is great danger of embolism when

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*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, Oct. 2d, 1918.

products of decomposition are set free by the electric needle in the rectal circulation, by the entrance of these products into the superior hemorrhoidal vein, to the inferion messenteric and through the portal vein to the liver where irreparable damage may occur. Or danger of cardiac embolism from the middle or inferior hemorrhoidal to the internal iliac, to the common iliac and through the inferior vena cava to the heart, should not be forgotten. What has been said of embolism resulting from the electric needle is also true of carbolic acid injections in hemorrhoids and these "absorbent methods" are not entirely free of pain as their advocates would have you believe.

Neiswanger has devised a special electrode, which when properly covered is inserted into the grasp of the sphincter. This electrode is connected to the positive pole and a large pad, previously wet, is attached to the negative pole and placed on the abdomen. By means of a rheostat a galvanic current of from 10 to 20 milliamperes is turned on for ten minutes to be repeated every other day. This treatment is free from pain, soothing and palliative to soft turgescent hemorrhoids, but is devoid of good results in pedunculated internal or old hard external hemorrhoids.

In 1916, Terrell of Richmond, Virginia, advocated the injection of Quinine and Urea in the treatment of chronic internal hemorrhoids, the chief symptom of which are protrusion and bleeding.

The writer has used this method in selected cases in his private practice and clinic with good results, it being free from pain, and safe when the injections are made through the mucous membrane, not into it, or sloughing will result. The strength of solution varies from 5 to 10 per cent depending on degree of resistance manifested by the hemorrhoid. Five per cent solution being the usual strength employed. Injections of five to eight minims are made into each hemorrhoid and but one or two hemorrhoids injected at a single treatment. These treatments may be given every other day until all hemorrhoids have received one injection, when the patient returns once a week, a cure being effected in from five to six weeks. The injection is made with a long syringe through a small needle and at a point as far away from the skin margin as possible. Before injection the hemorrhoid is cleansed with alcohol and iodine.

Quinine and Urea is contraindicated in strangulated, external, or inflamed piles but is a specific in properly selected cases.

No restrictions need be placed upon the patient during the course of treatment other than care as to daily evacuations.

This and the Neiswanger method are worthy of trial in that large class of cases which refuse operation, or in those whose condition is such that operation is contraindicated.

As to operative measures, there is no doubt that good results may be obtained by any of the methods, such as the clamp and cautery, the Whitehead operation, excision, with or without sutures, as advised by and carried out by their originators, so far as a radical cure is concerned. But the profession as a whole has not manifested any decided preference for any of these operations and the reason seems to be that their advantages are more than counterbalanced by the fact that it is practically impossible to perform any of them without first subjecting the patient to a profound general anesthesia. And notwithstanding that many of the former objectionable features of ether and chloroform narcosis have been greatly minimized by skillful administration of these agents in combination with nitrous oxide gas, ethyl chloride, etc., there yet remain many patients who regard as portentious all operations requiring general anesthesia.

After completion of examination the question is frequently asked if it is necessary to take ether; and it is safe to say that not more than 25 per cent of the cases that apply at physicians' offices, and dispensaries, would submit to operation, though suffering be extreme, if general anesthesia be required. The replacement of internal hemorrhoids after each act of defecation, the soiling of undergarments from hemorrhage, the pain incident to strangulation, when gripped by the external sphincter, soreness and pain at other times are among the annoyances these patients will endure for years, getting only temporary relief from pile salves, lotions, suppositories, etc., so extensively advertised.

During recent years it has been abundantly demonstrated that nearly all who are afflicted with hemorrhoids can be relieved just as radically and more safely by means of simpler measures, providing, the operation is undertaken by one who has mastered thoroughly the principles of infiltration

anesthesia, and familiarized himself with the difficulties encountered in applying these principles to rectal operations.

It is the writer's opinion that Allingham's method, the ligature operation, the foundation stone upon which all hemorrhoidal operations are based, with the single exception of the Whitehead, is the operation of choice where local anesthesia is employed. And it is doubtful whether any of the numerous modifications are of much practical value owing to the character of the tissue and peculiar anatomy of the anal canal. When it is recalled that the sphincter muscles act as a purse string constricting the anal canal and when internal hemorrhoids are present there is always a redundancy of mucous membrane, it can readily be understood that when the hemorrhoidal tumors are removed by the method to be presently described, the action of the sphincters external and internal serve the purpose of coapting the edges of the wound.

Careful preliminary examination is important to accurately determine the situation, size and number of tumors requiring removal as well as to ascertain whether any other conditions such as fissure, fistula, polypoid growths or malignancy are coexistent.

It is rare to find more than seven internal hemorrhoids in any single individual and when this number is present they assume the following arrangement:

The right anterior pile is invariably alone. It is the first to develop and can always be demonstrated, except in cases in which it may have sloughed in consequence of previous strangulation.

The right and right posterior are coalesced. The left and left posterior are coalesced.

The posterior pile and left anterior are distinct and usually smaller than the others. The anterior pile is seldom met with.

The highest number frequently met with in any single case does not exceed five, in which case the right and right posterior are occasionally distinct and likewise the left and left posterior. When piles are fewer in number they are generally distinct.

The usual preparation having been made, the patient being in the right semiprone position, the external sphincter muscle if found to be spasmodic and hypertrophied so that the hemorrhoids cannot be readily prolapsed can be easily dilated after injecting into it a few drops of the anesthetic in use, at the point of entrance of the lessor sphincterian nerves by inserting the needle in the posterior commissure three-fourths of an inch from the anus, from which single puncture the nerve supply of the anal circumference may be effectively blocked. The sprincter is next dilated and hemorrhoids prolapsed. They are operated on in rotation begining with the most anterior on the right side. The others are taken in order, those on the lower side being first removed, thus keeping the operative field from being obscured by oozing of blood.

Each tumor is in turn distended with novocain, ½ per cent, seized with a pile forcep, gently elevated, dissected upward until it is attached with a narrow pedicle containing the main blood supply. It will be remembered the artery and vein lie very near the mucous membrane and with the hemorrhoid elevated as described it is hardly possible to wound any large blood vessel.

A ligature is now tightly tied about the pedicle as high up as possible and the hemorrhoid cut off below the ligature leaving sufficient stump to securely retain the ligature. The internal hemorrhoids having all been ligated and removed, any folds of anal skin or tags that are clearly redundant should be removed. Their size and location should be noted before dilation of the sphincters as after dilation it is often difficult to estimate clearly the amount of tissue that requires removal. They can be painlessly removed after infiltration, by means of curved scissors. When folds are very numerous not more than three should be removed at one time lest anal contraction take place.

In the after treatment, careful attention should be given. The bowels should act on the second or third day and daily thereafter. Suitable laxatives being resorted to as required.

The anal region should be kept scrupuously clean and protected by wearing an anal pad of sterile gauze. After the ligatures have separated topical applications of 50 per cent balsam of Peru in castor oil, or ichthyol 15 per cent in glycerine, should be made to the anal canal to secure rapid healing.

Morning evacuations may be made easier and painless by the injection, the night before, of an ounce of sterilized olive oil.

The patient may be up and around after the second day.

In conclusion the writer wishes to say that all

hemorrhoids of whatever form, all fissures and the large majority of fistulae can be treated radically, satisfactorily and with but little discomfort to the patient without the use of a general anesthetic.

DISCUSSION.

Dr. B. H. Oberembt, Milwaukee: Mr. Chairman, and Gentlemen. I am very glad to hear this subject brought before the Wisconsin State Medical Society, because the field of rectal diseases is today the greatest bet for the advertising specialists, who advertise a permanent cure without the use of the knife. Practically all of these self-advertised specialists are men who were unable to make a living in the legitimate practice of medicine; most of them are the scum of the medical profession, who know little or nothing of pathology, symptomatology, or are unable to differentiate between a malignant and a benign growth. When you stop to realize that three-fifths of the cancers of the body are in the alimentary tract and that the most frequent portion of that tract affected is the rectum, it becomes a most important factor to keep the patient within the legitimate practice of medicine. The majority of hemorrhoids occur at the cancerous age of the patient. Therefore it is most important to make an accurate diagnosis in all these cases. The general practitioner has not paid enough attention to rectal diseases. Usually when a patient comes in complaining of pain or discomfort during defecation, the doctor simply sits down, writes a prescription for some hemorrhoidal suppositories, instead of making a thorough examination upon which to base his prognosis and treatment. If these suppositories do not help, as they most often do not, the patient goes from bad to worse, until he falls into the hands of the advertising specialist. Most hemorrhoids, fissures and allied condition of the rectum can be treated under local anesthesia just as efficiently and without much pain as under a general anesthesia. Many patients who would not submit to an operation under general anesthesia would submit to a radical cure under local anesthesia and consequently avoid many complications.

A TILT OF WITS.

In connection with lawyers trying to confuse experts in the witness-box in murder trials, a case is recalled where the lawyer looked quizzically at the doctor who was testifying and said:

"Doctors sometimes make mistakes, don't they?"

"The same as lawyers," was the reply.

"But doctor's mistakes are buried six feet under ground," said the lawyer.

"Yes," said the doctor, "and lawyer's mistakes sometimes swing in the air."

—*Kansas City Independent.*

EARLY SYMPTOMS OF ORGANIC BRAIN AND CORD DISEASE.*

BY D. W. ROBERTS, M. D.,

MILWAUKEE.

Permit me to assure you that in presenting for your discussion and kindly criticism the subject of the early symptoms of organic brain and cord disease that I am deeply sensitive of the importance of the theme to which I have subscribed. I shall not burden you with the details of neurological terminology, or dwell upon the differentiating features of the innumerable neuro-clinical entities, but shall emphasize some of the signs and symptoms which have occurred with so much regularity in the routine examination of the nervous system of a large number of sick people who have come to the Sanitarium for treatment for nervous breakdowns, neurasthenia, hysteria, melancholia, and to take the rest cure.

It seemed at first very unusual to find in this type of cases so much evidence of neuro-structural tissue changes, and becoming interested in these findings, I began making more painstaking neurological tests, and the more thorough the examination, the more evidence of organic disease was to be demonstrated. So the idea forced itself upon me that in order to find demonstrable evidence of organic brain and cord disease it was necessary that we look for it until we had exhausted every known method of testing out the functional capacity of the brain and spinal cord; then we could feel reasonably sure that our patient had no evidence of structural disease.

There is no excuse for the physician of today who makes a superficial and cursory examination of the individual's nervous system and calms their fears and anxieties with that ancient and bewhiskered assurance of medical wisdom that "you are nervous and run down and I can find no evidence of organic disease." The narcotic effect of this play on words soon wears away, and the pain, numbness, and other peculiar sensations return with the same intolerable miserableness. Then to other shrines with similar results until finally the neuro-structural changes have progressed to that degree where the evidence of impaired function

*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, Oct. 3rd, 1918.

reaches the requirements of the current text-book description. Then it is too late, for irreparable tissue damage has ensued and the golden opportunity for successful therapy has passed.

It seems that some reasonable explanation should be rendered why medical tradition should have left to its posterity such a discouraging and pessimistic legacy of therapeutic effort. The same could have been said about the other branches of medicine a few decades ago, but thanks to those great pathfinders of scientific speculation, investigation, and verification who were not content to rest with that which was obvious and known, but reached out into the darkness of the unknown with that enviable thoroughness of detail for which Fame has righteously awarded them the recompense of immortality.

It is an indisputable fact today that when pulmonary tuberculosis has advanced to that stage where the clinical and pathological picture corresponds to the text-book narrative, the therapeutic prognosis takes its place beside that accorded to the organic brain and cord diseases. The text-books in every branch of medicine must be re-written in view of the very rapidly widening circles of new diagnostic and therapeutic generalization.

Emerson says: "Our life is an apprenticeship to the truth that around every circle another can be drawn; that there is no end in Nature, every end is a beginning; that there is always another dawn risen on mid-noon, and under every deep another deep opens."

The prevailing conception of disease at present is founded upon the investigation of advanced and chronic changes of the tissues and organs of the body as observed and studied in large clinics and hospitals where every approved diagnostic method is being used to classify and suggest remedial measures of relief. If we consider the individual as a biological unit, endowed with a nervous system whose function is to bring the different organs and systems of the body into harmonious relationship, and further provide for the adequate adjustment of the body as a whole to the environment in which it resides, then it is not difficult to comprehend that any departure or interference with the physiological function in either environment would manifest itself to the consciousness of the individual as a sensation not normal and dependent upon a diseased condition of some organ. So then it is obvious that the earliest symptoms of organic disease are presented as sensations, unpleasant or disagreeable feelings, located in the various parts of the human anatomy. Now if we are to recognize and satisfactorily interpret these symptoms, we must give more attention to the analysis of the individual's first description of new and unusual sensations, for in the pursuit of these investigations we enter a field which lies wholly unexplored and holds the greatest possibilities of achievement that has occurred in the history of the practice of medicine.

It is a lamentable indictment, but nevertheless a just one, that we, as physicians, are drifting further away every day from the individual study of sick people and are giving too much consideration to groups and classes that have been determined by physical signs, laboratory findings, and post-mortem examination, all of which is well enough if we begin at the grave, but why not, in accord with the exalted and ennobling sentiments of the ethics of our profession, begin at the cradle, and indulge ourselves in the laudable endeavor to discover, recognize, and classify the abnormal sensations which are evidence of disease in its incipiency, so that we can institute methods of therapy which will either abort or arrest the pathological process so that irreparable tissue damage will not occur.

The functional capacity of every organ in the body as well as the harmonious co-operation of all the organs and systems of the body are dependent entirely upon the efficient functioning of the nervous system. Disordered function of the nervous system may result from inflammation, toxemia, degeneration, pressure, new-growths, or sclerosis, and the symptoms depend upon the particular part of the nervous system involved, and the clinical picture is dominated by a medley of signs and symptoms determined by the degree of impairment of function of the sensory, motor and trophic systems, and also the patient's mental ability to accurately interpret his sensations.

A practical working knowledge of the anatomy and physiology of the brain and spinal cord is most imperative, and in the formation of opinions in regard to the pathological process present, we must think always in terms of systems, paths, tracts, and individual nerve distribution, giving true valuation to the level or locality of the nerve tissue involved and keeping in mind the evidence of secondary adjacent organ complications.

One of the most difficult problems in clinical neurology is the recognition and differentiation of primary and secondary symptom groups. In the large majority of patients suffering from organic brain and cord disease, the secondary symptoms entirely overshadow and obscure the primary initial lesion. Further consideration of the symptoms of secondary impaired function resulting from organic brain and cord disease, would lead immediately into the wilderness of visceral neurology, which I shall not discuss at this time.

Every disease has its beginning, and during the period of time that exists between the beginning and the progress of the pathological process to structural changes in nerve tissue, and the establishment of objective signs and symptoms, there must exist a pre-organic, subjective state, characterized by peculiar sensations, exaggerated normal feelings, indefinite pains, numbness, and moods of unwarranted sadness, fear and anxiety, with which Nature has wisely endowed herself so that adequate warning would occur before irreparable damage had ensued.

This pre-organic subjective state of all organic brain and cord diseases must be recognized by all physicians, especially the general practitioners, who have the greatest opportunity to serve, because the patient presents this picture at the first consultation.

Some may say that all cannot be neurologists. That is very true, but it does not require a special neurological training to establish the facts that I have tried to present to you. My experience in the study of this problem forces me to conclude that every patient who presents the subjective state of indefinite pains, numbness, peculiar sensations, feelings of unusual weakness, tremors, insomnia, dizzy spells, and inexplicable sensation of distress, sexual weakness, lack of ability to concentrate, moods of unwarranted sadness, fear, anxiety, obsessive ideas of introspection, general feeling of not being well, and numerous other morbid sensory phenomena, should be considered a potential organic case until absolutely proven otherwise.

Many of these sick people are being seen every day by physicians and diagnosed as neuropaths, psychopaths, neurasthenics and hysterics, while others are being operated upon by sincere and eminent surgeons with the most unfavorable results, for they readily become surgical ghosts that haunt the path of glory that leads to success and fame.

The ability of physicians to recognize and interpret the earliest symptoms of disease is humanity's greatest weapon in her fight against disease and death. The field of subjective pathology, fabulously rich of achievement and service to mankind, lie wholly unexplored before you, and every patient who comes to you for medical advice becomes a specimen from this field for study and investigation, and if we are true to the faith and ourselves we must render service commensurate with the knowledge that we possess.

DISCUSSION.

Dr. Richard Dewey, Milwaukee: The paper which Dr. Roberts has given us has a special and, it seems to me, exceptional interest, as it covers ground that is apt to be overlooked, and I feel, as I think we all do, obliged to him for giving us so comprehensive a presentation of this subject.

The early symptoms of structural changes in brain and cord are apt to escape attention unless carefully looked for. Perhaps one of the most frequent pathological changes that is often lost sight of, is that in the mood or temper and conduct of the patient. The very general experience with me when the patients present themselves who are suffering from paresis, locomotor ataxia, or other organic degeneration of the brain, is that the friends will often say: "He has been so different from what he was before;" and yet they would go on for months, and sometimes years, with these differences observable, not attributing any importance to them. Invariably I believe, when patients become affected with paresis, and almost any structural form of disease, arterio-sclerosis of the cerebral blood vessels, or alcoholic degeneration, there is a marked change in the mood and tone of feeling; they actually become much more irritable and excitable, and will be noticed to be very different from what they formerly were. The change does not always take that form, however. In other cases there will be extreme depression and melancholia, a brooding and sullen disposition will appear. And so it is well to inquire whether the friends that have been familiar with the patient have noticed that he became different in his conduct and in his mood.

One remark which Dr. Roberts made, I feel is exceedingly truthful, but has a certain exception, and that is in regard to the examination of the patient and communicating to the patient the facts of the findings, especially where grave and perhaps incurable brain disease is discovered. It sometimes seems unwise to inform the patient immediately of the gravity of the situation, as it is apt to have a depressing effect, aggravating the symptoms, and might perhaps prevent improvement to a certain extent, which might otherwise occur in rare instances; but I agree entirely with the doctor that the exact truth of the findings should be communicated either to the patient himself or to his family or to those responsible for him.

The differentiation of these various organic troubles of brain and cord is an important matter, and also a very difficult one. The patients will be suffering perhaps from both syphilis and alcoholism, and a degenerative condition, as well as extreme nervous excitation, and will often present a problem in which only a period of observation will admit of medical clearing up.

Of the earlier symptoms that are sometimes overlooked, those affecting the cranical nerves are especially important. The eye symptoms especially may often give a view in advance of the natural declaration of the disease by other motor or sensory symptoms, local or focal. The study of the pupil and of the eye grounds, and of the cranial nerves, and in cases of tabes of the question whether the patient's pains are characteristic of cord disease, are very important. I have often known of lightning pains, Argyll-Robertson symptom, and other appearances of locomotor ataxia or paresis, being overlooked.

ROCKEFELLER FOUNDATION PROGRAM.

Extensive work in public health and medical education, and the completion of its war work, will comprise the program of the Rockefeller Foundation for the year 1919.

The estimated income of the fund for 1919 is $6,750,000, and against this the budget provides for $2,264,130 for public health and $3,662,504 for medical education. The other items of the budget are $103,000 for miscellaneous payments on long term appropriations and $146,662 for administration. The amount still available for appropriations is $465,110.

Of the income received in 1918, $2,787,406 has been brought forward to be used to meet appropriations for war work made in 1918, but yet to be paid.

The public health activities to be carried out during the year will consist chiefly of efforts against yellow fever, tuberculosis in France, malaria and the hookworm disease.

The Yellow Fever Commission, headed by General William C. Gorgas, is starting a war on the disease which it is hoped will result in its complete elimination.

The Commission on Tuberculosis in France, which during the war has been co-operating with the American Red Cross, will continue its work on an enlarged budget at the request of the French authorities.

Demonstrations in the control of malaria will be carried on in two southern states.

The campaign against the hookworm disease will be waged during the present year in twelve states of America and twenty-one foreign states and countries.

In addition to this public health work to be carried out by the Foundation's International Health Board, appropriations have been made for special studies and demonstrations in mental hygiene by the National Committee for Mental Hygiene, for the creation and maintenance of a School of Hygiene and Public Health at Johns Hopkins University, and for the development of public health nursing.

The Foundation's chief work of the year in medical education will be in connection with the development of training in modern scientific medicine in China through the Foundation's China Medical Board. This Board is developing a strong medical center at Peking, which will open this autumn, and is planning another medical school and hospital at Shanghai. The Board is also helping to strengthen medical work of other organizations already established throughout China, and is furnishing fellowships for medical study in America by Chinese physicians and nurses and of medical missionaries on furlough.

Other expenditures for medical education authorized are for special work of the Rockefeller Institute for Medical Research and toward a contribution made two years ago of one million dollars for the deveuopment of the medical school of the University of Chicago.

Expenditures of the Rockefeller Foundation war work in 1919 will be for the following:

Continued maintenance, at the request of the War Department, of the War Demonstration Hospital.

Work of Medical Division of National Research Council, which was appointed by the President to co-ordinate the scientific resources of the nation.

Assistance in care and treatment of soldiers mentally and nervously disabled.

Payments on pledges made in 1918 to United War Work Fund and to work under the direction of the Commissions on Training Camp Activities.

STETHOSCOPE SONG.

(By the Late Oliver Wendell Holmes.)

There was a young man in Boston town,
  He bought him a Stethoscope nice and new,
All mounted and finished and polished down,
  With an ivory cap and a stopper, too.

It happened a spider within did crawl,
  And spun him a web of ample size,
Wherein there chanced one day to fall
  A couple of very imprudent flies.

The first was a bottle-fly, big and blue,
  The second was smaller, and thin and long;
So there was a concert between the two,
  Like an octave flute and a tavern gong.

Now, being from Paris but recently,
  This fine young man would show his skill;
And so they gave him, his hand to try,
  A hospital patient extremely ill.

* * *

But since the case is a desperate one,
  To explore his chest it may be well;
For if he should die it were not done,
You know the *autopsy* would not tell.

Then out his stethoscope he took,
  And on it placed his curious ear;

Mon Dieu! said he, with a knowing look,
  Why, here is a sound that's mighty queer!

The *bourdonnement* is very clear—
  Amphoric buzzing as I'm alive!
Five doctors took their turn to hear;
  Amphoric buzzing, said all five.

There's *empyema* beyond a doubt;
  We'll plunge a *trocar* in his side.
The diagnosis was made out,
  They tapped the patient; so he died.

There was an old lady had long been sick,
  And what was the matter none did know;
Her pulse was slow, though her tongue was quick;
  To her this knowing youth must go.

So there the nice old lady sat,
  With phials and boxes all in a row;
She asked the young doctor what he was at,
  To thump her and tumble her ruffles so.

Now, when the stethoscope came out,
  The flies began to buzz and whizz;
Oho! the matter is clear, no doubt;
  An *ancurism* there plainly is.

The *bruit de rape* and the *bruit de scie*
  And the *bruit de diable* are all combined;
How happy Bouillaud would be
  If he a case like this could find!

Now, when the neighboring doctors found
  A case so rare had been described,
They every day her ribs did pound
  In squads of twenty; so she died.
Then six young damsels, slight and frail,
  Received this kind young doctor's cares;
They all were getting slim and pale,
  And short of breath on mounting stairs.

They all made rhymes with "sighs" and "skies,"
  And loathed their puddings and buttered rolls,
And dieted, much to their friends' surprise,
  On pickels and pencils and chalk and coals.

So fast their little hearts did bound:
  The frightened insects buzzed the more;
So over all their chests he found
  The *rale sifflant*, and the *rale sonore*.

He shook his head—there's grave disease—
  I greatly fear you all must die;
A slight *post-mortem*, if you please,
  Surviving friends would gratify.

The six young damsels wept aloud,
  Which so prevailed on six young men,
That each his honest love avowed,
  Whereat they all got well again.

Now use your ears, all that you can,
  But don't forget to mind your eyes,
Or you may be cheated like this young man,
  By a couple of silly, abnormal flies.

AN APPEAL FOR NATIONAL MEDICAL RECIPROCITY.

In the interest of the Morale of the Medical Officers who have been left in the service since the signing of the Armistice and as an act of simple justice to all Medical Men who have abandoned their work in civil life to serve in the Army during the War, an effort should be made through the Governors of the several states or otherwise to secure for the ones who are Graduates of Reputable Medical Colleges and who have made Good Records the right to practice in any State in the Union without examinations. This suggestion is supported by the following:

(A) The object of all Medical Practice Laws is to protect the public from ignorant and vicious Practioners of Medicine. No State Law regulating the practice of Medicine is passed on any other theory, nor for any other purpose. The Graduates of reputable Medical Schools selected for Army Service and especially those who have made good records in the Army meet all of the requirements demanded by all state laws governing the Practice of Medicine.

(B) Practically all states grant to Medical men in the Army and Navy the right to practice in Civil Communities while in the Service. If these men meet the requirements while in the Army and Navy, they certainly meet the requirements when retired to civil life.

(C) Many Medical Men have been made proficient in special branches of Medicine during the War and should be given opportunity to select new locations in which to begin practice as Specialists.

(D) Some men have in addition to the loss of their civil practices been broken in health and will find it necessary to begin work again in different climates and environments.

(E) Many having lost their practices at home will find it easier to begin life all over again in new localities. This is particularly true of those who have been much reduced in financial standing. They should be spared the humiliation of having to begin at the bottom and to compete on unequal terms with old competitors who have profited by their absence from home.

(F) The last men to be released from the Service will be the most in need of encouragement and help in every possible way. During the War they were regarded by their patients as patriotic men making sacrifices during a great national emergency. Now that the War is over they are thought to be remaining in the Army as a matter of choice and are therefore more often censured than praised. The men first out of service will very naturally get the best of whatever practice is recovered by the returning Medical Officers.—"The Camouflage," Base Hospital, Camp Wheeler.

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ROCK SLEYSTER, M. D., Editor
Waupun

J. P. McMAHON, Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:

OSCAR LOTZ, M. D., Milwaukee
JOS. SMITH, M. D., Wausau
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EDITORIALS

ANNUAL MEETING.

Place .....Milwaukee
Time.....October 1, 2 and 3, 1919
Host.....Milwaukee County Medical Society
Program.....The very best
Features.....“Victory” meeting
Those Responsible....C. H. Lemon, Milwaukee, General Chairman, Program Committee.

Medical Section—L. F. Jermain, Milwaukee, Chairman; C. R. Bardeen, Madison, Secretary.

Surgical Section—W. Cunningham, Platteville, Chairman, D. Hopkinson, Milwaukee, Secretary.

Eye, Ear, Nose and Throat Section—Franz Pfister, Milwaukee, Chairman; Chas. Zimmermann, Milwaukee, Secretary.

Chester M. Echols, Milwaukee, Chairman, Arrangement Committee.

This will be the largest and best meeting of the State Society ever held. Make your plans to attend the “Victory” meeting now. Write those in charge about anything you can suggest or contribute to its success.

LEST WE FORGET.

THE DEATH TOLL AMONG PHYSICIANS HAS BEEN VERY HEAVY DURING THE PAST FEW MONTHS. LET US KEEP OUR LIFE INSURANCE POLICIES PAID UP. THEN THERE ARE OUR DUES TO THE COUNTY SOCIETY WHICH BECAME DUE THE FIRST OF JANUARY. WE WANT TO BE IN GOOD STANDING IN THE STATE SOCIETY AND ENTITLED TO ITS MEDICAL DEFENSE FUND. IF ANY OF US HAVE NOT ALREADY PAID OUR 1919 DUES LET US SEND OUR CHECK AT ONCE TO OUR OVERWORKED AND UNDER-PAID COUNTY SECRETARY, THEREBY SAVING HIM THE NECESSITY OF SENDING US REPEATED NOTICES. PROMPT PAYMENT WILL ALSO SAVE US THE HUMILIATION OF LETTERS FROM THE AMERICAN MEDICAL ASSOCIATION ASKING ABOUT OUR STANDING IN THE MEDICAL ORGANIZATION.

HONOR ROLL.

THE following sixteen county societies met all requirements and sent in 1919 dues for all members before February first. This is an exceptionally good showing and the honors of the society go to the secretaries of these associations this year. Dr. John Baird, secretary of the Douglas County Society, broke all records by sending in a complete membership report on December 31, 1918.

Calumet
Columbia
Door
Douglas
Green
Green Lake-Waushara-Adams
Jefferson
Langlade
Lincoln
Manitowoc
Marinette-Florence
Monroe
Outagamie

Ozaukee
Racine
Rusk

Other component societies of the state association stood as follows on February first. Are any of you who read this to be blamed because your society is not on the honor roll? Send in your dues today!

75% CLASS.

Chippewa
Dodge
Dunn-Pepin
Eau Claire
Grant
Juneau
La Crosse
Portage
Price-Taylor
Richland
Rock
Sauk
Shawano
St. Croix
Trempealeau-Jackson-Buffalo
Vernon
Waukesha
Waupaca
Winnebago
Wood

50% CLASS.

Ashland-Bayfield-Iron
Barron-P.-W.-S.-B.
Crawford
Dane
Iowa
Kenosha
Marathon
Milwaukee
Washington

25% CLASS.

Clark
La Fayette
Oconto

NO REPORT.

Brown-Kewaunee
Oneida-Forest-Vilas
Fond du Lac
Sheboygan
Walworth
Pierce

THRIFT—A NATIONAL PRESCRIPTION.

IN their work for the comfort and well-being of the human race, doctors have in the last year or so gained a staunch and powerful ally, namely, the habit of THRIFT, which has been fostered in the American people by the various forms of Government loans.

During the past years, the idea, one long held by the Chinese, that prevention is better than cure and that attention to causes should be so intense that causes themselves would be eliminated, has been strongly advocated by the profession. In this connection, they are all well aware that the average chronic afflictions of the patients they were called upon to aid were due to over-keyed modes of life.

Despite the increased demands laid upon individuals by the war, the present day finds the people of the nation in a better state of health than before the recent days of thoughtful consideration.

The typical American had, for the last ten or fifteen years before the war, been gaining a momentum in the speed of his life which threatened to result disasterously. The constant craving for pleasure, the demand for pre-digested forms of amusement and the abandonment of the quieter pleasures of simple existence had been excused by the business man as "necessary to take his mind from the routine of the day."

Then the war introduced into the intensified, almost hectic existence of the average family a serious element. True Americanism demanded the curtailment of non-essential consumption of either materials or human labor. Non-essentials eliminated from the fabric, the texture of American life became more concretely beautiful. The necessity of economy was brought forward more forcibly when the people were called upon to subscribe to Liberty Loans and to buy War Savings and Thrift Stamps.

When people are confronted with the duty of curtailing to the limit all expenditures, it is the luxuries that must perforce be cut from the list. And it is the luxuries that are for the most part most harmful from a physical and a psychological point of view. Simpler foods, less self-indulgence in the matter of sweets, alcoholic liquors, etc., less "night-life" and more of the simpler joys of outdoor exercise and good reading have produced a new strength in the American family.

Now that the war is over, the wounds of a war-torn world must be healed, and Government loans will be called in various forms to meet the expenses of the prescriptions of reconstruction deemed imperative by our leaders.

The medical profession has two aims in preaching THRIFT to the people. Let every reader of THE WISCONSIN MEDICAL JOURNAL instruct his patients to save for the next Liberty Loan and to invest in War Savings Stamps, not only to strengthen the great country where every man, woman and child is given a fair chance, but finally and completely to defeat that false modern god of Keeping-Up-Appearances. It has been the constant struggle for ostentatious show, the com-

petition of extravagance, which has in the past years spelled nervous breakdown to many a man. A more invigorating tonic than a substantial capital, saved out of current earnings, cannot be conceived.

INFLUENZA PROPHYLAXIS.

IT is difficult for a rank outsider to understand how the special Influenza Committee of the American Public Health Association (published in full in the "Journal, American Medical Association," December 21, 1918), could utterly have ignored the consideration of chemical disinfectants as a means of controlling the spread of the epidemic. Vaccines were considered at length in the general discussions of the meeting and briefly by the Committee, notwithstanding Park's sage remark that: "One cannot fight an unknown germ by means of known germs."

The Committee opines with everybody else—that the unknown organism enters and leaves its victims through nose and throat. It is known that many organisms which infest the external respiratory passages can be successfully controlled by silver salts and other chemical disinfectants. Why, then, do not these scientists consider—if only to condemn—the use of chemical prophylactics instead of wasting time considering biologic shotgun methods? H. E. D.

DR. JOHN SMITH VS. JOHN SMITH, M. D.

DR. John Smith may, by the casual observer, be mistakenly credited with a degree in divinity, philosophy or dentistry. Again, Dr. John Smith may be classified by the casual observer as an osteopath, chiropractor or chiropodist. John Smith, M. D., however, is instantly and properly recognized as bearing the degree of Doctor of Medicine.

This may seem at first glance a small subject for discussion, but in larger communities, especially, it is worthy of consideration, and the members of this society are respectfully urged to unite in adopting for universal use the specific degree letters, *M. D.*, rather than the obscure and much overworked prefix, *Dr.* or *Doctor.* In Pennsylvania the degree, *M. D.*, represents several years of college and hospital work; on the other hand, the prefix, *Dr.*, adorns the stationery or sign of many an individual who took but a few weeks' course in some school of drugless therapy.—*Exchange.*

VENEREAL DISEASE AND PEACE.

THE sacrifices of the world war have not been without some compensations. Not the least among these is an enlightened opinion which must now be lined up behind the organized campaign to protect the youth of this country from venereal disease. Four million soldiers and sailors have, under the protection of the military authorities, received greater protection than received in civil life. The signing of the armistice in no way lessens the responsibility of protecting these boys from prostitution and liquor. Our states and cities ought never to lose the control which has been established over our youth. These communities to which the discharged soldier or sailor will return must be made safe.

Before the war, the physician and public health officer knew the part played by venereal disease in the production of our blind, our mental defectives, our surgical cases in women, locomotor ataxia, paresis, miscarriages, etc. But the people generally did not know these things and there was no enlightened public opinion back of measures instituted to suppress the evils responsible for them. The reports of our draft boards and camp surgeons have, however, made these matters plain to the layman, and the time is ripe for the program being enacted by the U. S. Public Health Departments. Let the medical practitioner sense his responsibility to lend a whole-hearted support.

The report of the Surgeon General shows that Veneral Disease has again constituted the greatest cause of disability in the army, and, as most cases were brought in upon the induction of registered men, the responsibility is placed squarely on the civilian communities. The army has done more than its part but what has your community done and what plans are you making?

Wisconsin stands well in the table which follows, but a record of 1.21% of venereal disease in Wisconsin draftees is an everlasting disgrace to the manhood of the state. It needs our serious consideration of the problem at home. The figures here furnished are from the office of the Surgeon General and apply only to the first million men. Later reports may change these results, but it is not necessary to await them to sense the responsibility of Wisconsin communities in this campaign.

RECORD OF STATES.

		%
1.	Oregon	0.59
2.	Idaho	0.76
3.	Utah	0.79
4.	Washington	0.66
5.	Montana	0.89
6.	South Dakota	0.95
7.	California	1.15
8.	Wisconsin	1.21
9.	Wyoming	1.22
10.	N. Hampshire	1.22
11.	Nevada	1.40
12.	Nebraska	1.53
13.	Vermont	1.53
14.	New Jersey	1.55
15.	Minnesota	1.57
16.	Connecticut	1.60
17.	Iowa	1.63
18.	Massachusetts	1.66
19.	Arkansas	1.73
20.	North Dakota	1.75
21.	New York	1.82
22.	Alaska	1.90
23.	Michigan	1.95
24.	Maine	2.02
25.	Colorado	2.12
26.	District of Col.	2.14
27.	Kansas	2.38
28.	Illinois	2.44
29.	Pennsylvania	2.62
30.	Rhode Island	2.66
31.	New Mexico	2.68
32.	Delaware	2.78
33.	Ohio	3.24
34.	Maryland	3.28
35.	Indiana	3.33
36.	Louisiana	3.32
37.	Arizona	3.40
38.	Missouri	3.52
39.	Kentucky	3.77
40.	Tennessee	3.80
41.	North Carolina	3.90
42.	West Virginia	4.00
43.	Mississippi	4.05
44.	Oklahoma	4.50
45.	Texas	4.70
46.	Georgia	5.60
47.	South Carolina	8.04
48.	Virginia	8.45
49.	Alabama	8.68
50.	Florida	8.90

THE JOURNAL CLINIC

FOUR CLINICAL RECORDS AND QUASI-DEDUCTIONS.

DRS. SKEMP AND LAVAL,

ST. FRANCIS HOSPITAL.

LA CROSSE.

CLINIC OF DRS. EVANS AND BANNEN.

The following records from the service of Drs. Evans and Bannen are presented because of the interest they may have or serve, and because of the therapeutic suggestions they may possibly harbor. The material is too meager for deductions; it is only hoped that an avenue of thought may perhaps be made a little more illuminant by them, granted that it has been previously opened.

The first record is one concerning pernicious vomiting, presumably. Therapeutic abortion had been strongly advised before the patient entered the hospital.

The essential data: Age 24. First pregnancy, of 2 months' duration. Picture of profound toxemia; air hunger, rapid respiration, rapid thready pulse. Alveolar air tension 15. Urine showed a large amount of acetone and diacetic acid. Blood examination normal. Vomiting had been incessant for five days prior to admission. The prognosis was obviously bad; the indications, to meet the acidosis, suggested the Murphy drip and the duodenal tube. 1000 c.c. of 1 per cent Sodium Bicarbonate and 5 per cent glucose given per rectum. Duodenal tube passed and ¼ gram cocaine and 3 grains chloretone administered into stomach. Tube passed into duodenum, and malted milk and sodium bicarbonate solution fed through it for several hours. The following morning the patient seemed completely metamorphosed. She retained small quantities of liquids; her alveolar tension had mounted to 30. The acetone and diacetic acid were diminished and in a few days recuperation seemed complete. The train ride home caused a recurrence; at least patient ascribed the mild recrudescence to the train ride. Soda per rectum corrected the distorted metabolism, and 18 days after first admission, patient left the hospital feeling fit. A recent report says she is feeling well and not vomiting.

Record two concerns a bilateral facial palsy in a boy of nine years. Two days prior to entrance, the mother noted that her son's face became sober during a hearty laugh. The laughing expression of the eyes did not change. No subjective symptoms until the day following, when he complained of being unable to keep liquids in his mouth and to swallow readily unless the food and drink were put directly into his pharynx. The pupils were widely dilated, the mother noticed, but they reacted readily to light. The paternal grand mother was insane, and paralyzed.

The picture was one of classical Bell's palsy. Physical and laboratory examination otherwise normal. On the second day urticaria appeared over entire body; on the fourth the first signs of improvement appeared, and the course was progressively on to complete recovery within a short time.

Records three and four concern intussusception. Case one came to operation after 24 hours of a characteristic intussusception history had been enacted. Pain, bloody mucus stools, vomiting and a mass in lower abdomen were all present, coming on acutely in an 11 months babe, whose health prior had been excellent. Operation by Dr. Bannen revealed ileum invaginated in caecum. "Milking" the tumor downward and gentle traction effected reduction; appendix was drawn through stab wound; appendix opened and small catheter inserted into caecum. During first six hours six ounces of fecal contents passed through appendicostomy tube. During first post operative day child had convulsion, which was easily controlled. Temperature normal on the 5th operative day, and child left hospital 7 days later, well.

Record four, child of six months came to operation three days after onset of pain, bloody mucus stools, vomiting; mass definitely outlined in lower abdomen, a little to the left of mid-line. Per rectum the tumor easily palpated, the lower margin of the intussusception being easily made out. Dr. Evans operated and reduced the mass by careful stripping from below and pressure above mass. About 5 inches of ileum and cecum including the appendix were telescoped in the colon. The mesentery border was infiltrated and the serosa eroded and congested, appendicostomy done here too—and soda bicarbonate given through the appendix opening and also by drip method into rectum. The first few days were extremely critical for the babe,

but it responded and went on to complete convalescence in a short while.

Realizing the calamities in medicine that are the direct results of premature conceptions and hastily drawn conclusions we must present these facts with their implied deductions with a grain of salt. Cases of pernicious vomiting, though no worse than the one reported have resisted all types of therapy and have died. Intussusception statistics are bad. The rule is that cases requiring resection uniformly die; the innocent procedure of appendicostomy adds little to the shock and much to the balance of safety. The lessons taught us seemed so refreshing after the calamities were rehearsed that, though we realized the paucity of data for worthy ideas, we dared present them for the few grains of value they might contain.

MEDICAL MOBILIZATION AND THE WAR

CHECKING UP THE WOUNDED.

When the first transports began to arrive in New York City with the wounded, the American Red Cross was already on the job with a system that has proved itself to be amply adequate to handle the situation.

Every day by mail and telephone came inquiries regarding some friend or relative who should have arrived and anxious hearts waited eagerly for news.

Information on sick and wounded is handled through the Department of Military Relief in the following manner:

Just as soon as a transport arrives a complete list of the sick and wounded on board is handed to the Red Cross Official at the pier. Four copies of this list are then made, one is sent to Army Headquarters; one to the Casualty Bureau; one is retained by the Red Cross and one copy is sent to the Hospital Director. After the men are sent to the hospitals, each Field Director checks up the men assigned to his hospital, the news is sent in to Red Cross Headquarters in New York City by messenger, is then card indexed immediately, one copy is sent to the Casualty Bureau and one copy to W. R. Castle, Jr., in charge of the National Bureau of Communications, at Washington, D. C.

For the information of those adjacent to New York City it may be desirable to add the following addresses:

Department of Miltary Relief, Atlantic Division of American Red Cross, 44 East 23rd Street, Gramercy 5100. Casualty Headquarters, 20 East 38th Street, Murray Hill 10450.

COURIER SERVICE FOR SOLDIERS' FAMILIES.

In view of the many inquiries that are being made concerning the welfare of soldiers in the American Expeditionary Forces, the War Department has recently instituted a courier service between America and France to get information desired.

This has been done because the quick demobilization of the army and the rapid change from place to place of different units have made it almost impossible for the Red Cross in France to follow up all inquiries satisfactorily.

In cases where there is doubt concerning reports that a man has been wounded, in fact in all casualty cases, the Bureau of Communication at National Headquarters of the American Red Cross, Washington, D. C., will continue to handle inquiries, but "straight welfare inquiries" should, in future, be made to the

ADJUTANT GENERAL,
WAR DEPARTMENT,
Washington, D. C.,

instead of to the Red Cross.

VOLUNTEER MEDICAL SERVICE CORPS.

The Council of National Defense authorizes the following:

Early in February each physician in the United States exclusive of those who served in the Medical Corps of the Army for the past two years and members of the Volunteer Medical Service Corps, received a communication from the Council of National Defense, requesting that he fill out and return promptly to the Washington office an accompanying questionnaire, so that there may be on file in Washington complete individual information covering the members of the profession. Simultaneously with the distribution of these questionnaires, state and county representatives of the Volunteer Medical Service Corps were instructed to urge all doctors in their communities to comply promptly with the request of the Council to fill out and forward promptly to Washington the blanks sent them; and to advise those who by any chance failed to receive blanks, to communicate with the Council of National Defense at once in order that application blanks might be furnished them.

The Volunteer Medical Service Corps was organized early in 1918 to serve the Government during the emergency of war. As this emergency has ceased to exist, active membership in the Corps is no longer solicited. However, the survey initiated by this organization last year has proved of such value as a source of information concerning the individual members of the medical profession that the Surgeon general of the Army, Navy and Public Health Service have requested the Council of National Defense to complete it so as to include every doctor in the country, in order that a permanent record of the profession may at all times be available for refer-

ence in future emergencies. Upon their completion, the records will be transferred to the Surgeon General's Library where they will be kept up to date by a force assigned for the purpose, and be accessible to all government bureaus.

Every physician is requested to co-operate with the Council of National Defense in making this record complete by returning at once the questionnaire received or by writing to the Medical Section of the Council of National Defense, Washington, D. C., and requesting that a blank be sent him if through an oversight he did not receive one.

MEDICAL CO-OPERATION IN THE SELECTIVE SERVICE SYSTEM.

The second report of the Provost Marshal-General to the Secretary of War covering the operations of the selective service system to Dec. 20, 1918, has just been made available. The interest physicians have taken in the work, and the service they have rendered in the various boards connected with the selective service system, gave assurance that much in this report would concern the medical profession. This prophecy is fulfilled. A few instances: Medicine is credited with supplying 4,246 of the 13,564 members of the local boards (31.3 per cent.); in addition, there were established 155 district boards on each of which there was at least one physician, and 1,319 medical advisory boards with a personnel of 9,577.

WAR NOTES

Captain C. J. Heath, formerly of Marshfield, has recently visited his parents in that city. Captain Heath before the war practiced in Utah and has gone west to look for a new location.

Major S. W. Doolittle of Lancaster has been appointed chief of the surgical staff of Base Hospital 76.

Major J. R. Longley of Fond du Lac is chief surgeon of the American forces in Archangel, Russia.

Colonel G. E. Seaman, chief medical officer of the 32d Division, and later of the Sixth Army Corps, returned to his home in Milwaukee from over seas service, February 25th. Colonel Seaman was transferred to the Sixth Army Corps after the battle of Argonne and was later stationed at Metz with the army of occupation.

Major George Harrison of Ashland has arrived home after several months service over seas. He is on a thirty day leave after which he will return to camp.

Doctor M. Villain, representing the surgeon general of the French Army, addressed the Medical and Dental fraternity of Marquette University, March 3d, on war surgery of the mouth and face.

Doctor M. H. Draper of Waterloo with the 32d Division in Germany has been promoted to the rank of captain.

Doctor H. M. Ripley of Kenosha, now with the army of occupation, writes of having rolled a few balls down the concrete bowling alley built in the headquarters of Crown Prince Frederick of Germany, last summer. Doctor Ripley writes, however, that it does not compare with the good old alleys at home.

Doctor W. J. Frawley of Appleton has been promoted to the rank of captain.

Captain and Mrs. Frank Brockway of Oshkosh recently spent a two weeks' leave of absence at home. Captain Brockway is assigned to army hospital 16, a tuberculosis sanatorium for soldiers who have returned from over seas.

Lieut. Colonel John L. Yates returned from service over seas, January 28th.

Major C. J. Combs of Oshkosh is with the army of occupation at Coblenz.

Authority to appoint members of district and local draft boards as "Brevet Majors" in recognition of their services to the country, is provided in a bill introduced by Senator Jones, of Washington, and referred to the Military Committee. The measure also would authorize the Secretary of war to award bronze medals to the board members.

Dr. G. L. Bellis, medical superintendent of Muirdale Tuberculosis Sanatorium, Wauwatosa, major in the governmental medical service, assigned to tuberculosis work in France, who was expected to return in February, has been reassigned for service in Italy for six months or longer.

Battle death rates in the American army during the great war exceeded the death rates from diseases, Gen. March announced in making public statistics prepared by the general staff. In past wars diseases killed many more men than lost their lives under fire. The battle death rate for the entire American army in this war was twenty per thousand per year. In the expeditionary forces it was fifty-seven per thousand per year. The disease death rate was seventeen per thousand per year in the expeditionary forces and sixteen in the army at home. Among the American forces the table showed, the battle death rate was only half that of the British expeditionary forces which was given as 110 per thousand per year. In the Mexican war fifteen per thousand were killed and 110 per thousand died of disease. In the civil war the northern forces lost thirty-three per thousand from battle and sixty-five per thousand from sickness. In the Spanish-American war five per thousand were killed in action while seventeen per thousand were the victims of disease.

Capt. O. C. Festerling, who has been in charge of the medical department at the Wilbur Wright aviation field at Dayton, Ohio, for the past twenty months, is home

at Reedsville on a furlough visit. Capt. Festerling expects to complete his service with the government within the next three months and will return to Reedsville to resume his practice there.

Lieut. Stanley Van Heckle of Tomahawk has been selected with thirteen other military doctors for service with the American army in Siberia. He has been spending a furlough with relatives in Tomahawk.

Maj. Clarence A. Baer, M. D., has received another decoration to add to his collection of medals. The Milwaukee physician is one of the six men who can boast of being accorded the privilege of wearing the Polish eagle. Four Poles, among them Ignace Paderewski, have thus been honored, while the fifth man was an American, Dr. Burlingame. Dr. Baer received the honor because of his service to Poland in hospitalizing sick natives. The decoration itself is diamond shaped, wrought in silver, and embellished with the Polish eagle with its wings outstretched. Besides this distinction he is the only American who may number among his war trophies the Reconnaisance Francaise.

Dr. J. C. Elsom, for many years head of the department of physical training at the University of Wisconsin, has been promoted to the rank of captain in the medical corps. He is director of physio-therapy at hospital No. 3, Colonia, N. J.

HONORABLE DISCHARGES, MEDICAL CORPS, U. S. ARMY.

H. G. Mertens, Bayfield.
J. M. Ross, Bloom City.
F. S. Tuffley, Boscobel.
W. P. Forkin, Chilton.
H. A. Jefferson, Clintonville.
J. E. Donnell, Cuba City.
C. W. Rice, Delavan.
E. J. Phelps, Elderon.
F. P. Marshall, Fond du Lac.
G. W. Fifield, Janesville.
W. A. Munn, Janesville.
G. W. Reis, Junction City.
G. J. Flanagan, Kaukauna.
H. A. Robinson, Kenosha.
A. A. Maurer, La Crosse.
O. F. Partridge, Mattoon.
J. C. Docter, Mayville.
C. E. Myers, Milladore.
L. J. Bachinski, Milwaukee.
G. H. Dickinson, Milwaukee.
P. J. Eisenburg, Milwaukee.
W. W. Gillespie, Milwaukee.
H. J. Gramling, Milwaukee.
J. E. Madison, Milwaukee.
L. M. Warfield, Milwaukee.
W. M. Gratiot, Mineral Point.
A. L. C. Borchardt, New London.
R. J. Goggins, Oconto Falls.
N. Andrews, Oshkosh.
E. F. Bickel, Oshkosh.
H. J. Haubrick, Oshkosh.
T. E. Farrell, Seneca.
R. M. Nichols, Sheboygan.
J. J. Minahan, St. Nazianz.
R. E. Doern, Stockbridge.
A. M. Farrell, Two Rivers.
C. E. Lauder, Viroqua.
F. C. Haney, Watertown.
R. C. Faulds, Abrams.
A. J. Gerend, Cato.
E. L. Bolton, Chilton.
H. C. Wiger, Dallas.
W. O. Seemann, Eau Claire.
B. I. Pippan, Excelsior.
S. E. Gavin, Fond du Lac.
G. H. Lawrence, Fond du Lac.
H. A. Rice, Gays Mills.
D. F. Gosin, Green Bay.
E. S. McNevins, Green Bay.
F. B. Welch, Janesville.
S. W. Murphy, Kenosha.
D. B. Dishmaker, Kewaunee.
M. S. Corlett, Madison.
K. W. Smith, Madison.
M. Staehle, Manitowoc.
D. C. Harrison, Mason.
F. C. Griswold, Mazomania.
H. C. Dallwig, Milwaukee.
W. G. Darling, Milwaukee.
F. A. Forsbeck, Milwaukee.
F. H. McLaughlin, Milwaukee.
D. D. Mehigan, Milwaukee.
E. D. Rigby, Milwaukee.
S. J. Seeger, Milwaukee.
E. H. Sutter, Milwaukee.
E. H. Federman, Montello.
C. J. Ouellette, Oconto.
M. M. Buneh, Oshkosh.
C. H. Nims, Oshkosh.
C. M. Schuldt, Platteville.
G. H. Benson, Richland Center.
F. W. McKee, Richland Center.
E. S. Ryan, Sheboygan.
W. E. Ground, Superior.
F. D. Jackey, Thorp.
A. F. W. Ottow, Watertown.
Rock Sleyster, Waupun.
H. T. Schlegel, Wausau.
J. A. Cox, Wautoma.
O. P. Schoofs, Wauwatosa.
B. E. Scott, Berlin.
R. C. Pfeil, Bowler.
M. A. Bailey, Fennimore.
B. O. Bendixen, Kewaskum.
P. Leicht, Lake Mills.
E. F. Baur, Milwaukee.
G. C. Ruhland, Milwaukee.
J. M. Baasen, Mount Calvary.
J. F. Schneider, Oshkosh.

C. G. Shannon, Sheboygan.
G. Parke, Viola.
V. F. Marshal, Appleton.
W. A. Prouty, Burlington.
H. C. Mix, Green Bay.
S. M. Kyes, Owen.
C. W. Andrews, Waupaca.
C. A. Fidler, Milwaukee.
C. U. Senn, Ripon.
C. C. Lawhorn, Milwaukee.
S. C. McCorkle, West Allis.
C. W. Lockhart, Mellen.
C. N. Stuesser, Oconomowoc.
H. S. Roby, Milwaukee.
W. B. Campbell, Menomonee Falls.
G. A. Thielke, Wausau.

ORDERS TO OFFICERS, MEDICAL CORPS, U. S. ARMY.

To Aberdeen, Md., from Lee Hall, Va., Lieut. E. C. Pfeifer, Sheboygan Falls.

To Camp Beauregard, La., from Camp MacArthur, Lieut. W. T. McNaughton, Milwaukee.

To Chicago, Ill., from Fort Oglethorpe, Lieut. H. O. Jones, Denison.

To Fort Biscum, Alaska, from Fort Riley, Lieut. R. F. Fitch, Tomah.

To San Francisco, Calif., from Vancouver Barracks, Capt. H. A. Fulton, Eau Claire.

To Camp Dodge, Iowa, base hospital, from Fort Riley, Major W. T. Clark, Fort Atkinson. To examine the command for cardiovascular diseases, from Lakewood, Lieut. B. F. Woch, Wauwatosa.

To Camp Grant, Ill., from Camp Lewis, Lieut. L. M. Pearson, Tomahawk; from Newport News, Va., Lieut. J. F. Schneider, Oshkosh.

To Fort Des Moines, Iowa, from Camp Upton, Lieut. A. Yaffe, Milwaukee.

To Fort San Houston, Texas, from San Antonio, Capt. C. H. Meyst, Burlington.

To Fort Sheridan, from Camp Cody, Capt. C. O. Decker, Crandon.

To Fort Snelling, Minn., from Fort Oglethorpe, Capt. R. W. Jones, Wausau.

To Oteen, N. C., for instruction, from Camp Joseph E. Johnston, Capt. B. F. Hoyt, South Kaukauna.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to his proper station, from Camp Custer, Lieut. I. E. Levitas, Green Bay.

To Fort Logan H. Roots, Ark., from Camp Logan, Lieut. E. L. Schroeder, Shawano.

To Fort Porter, N. Y., from Camp Jackson, Capt. S. G. Pake, Hayward.

To Fort Sheridan, Ill., from Fort Riley, Lieut. P. J. Merten, Milwaukee.

To Camp Lewis, Wash., as tuberculosis examiner, from Vancouver Barracks, Lieut. L. F. Ruschaupt, Milwaukee.

To Camp Sherman, Ohio, as tuberculosis examiner, from Fort Riley, Capt. J. W. Lockhart, Oshkosh.

To Camp Travis, Texas, as tuberculosis examiner, from Camp Beauregard, Capt. A. Egdahl, Menomonie.

To Fort Sheridan, Ill., from Camp Dix, Capt. F. E. Andre, Kenosha; from Camp Grant, Lieut. L. E. Youmans, Mukwonago.

To Walter Reed General Hospital, D. C., from the Surgeon-General's Office, Capt. B. H. Holmes, Delavan.

All good team work arouses my enthusiasm. Football, part singing, machine politics, even house breaking are admirable so far as team play is manifest in them. But of all the forms of medical team play to which the spirit of our times is leading us, none seems to me so fruitful, so full of efficiency and of promise, as that in which doctor and patient get together against their common enemy—disease.—Dr. Richard C. Cabot.

BOOK REVIEWS

An Introduction to Neurology. By C. Judson Herrick, Ph. D., Professor of Neurology in the University of Chicago. Second edition, reset. 12mo of 394 pages, 140 illustrations. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $2.00 net.

This little work is designed as an introduction to the subject of neurology. The author refers the student to the larger medical textbooks of anatomy, physiology, and neurology for detailed descriptions, and confines this work to a schematic outline of the subject. The work has been prepared in the hope that it will help the student to learn to organize his knowledge of the different functional patterns earlier in his work than is often the case and to appreciate the significance of the nervous system as a working mechanism from the beginning of his study.

The subject is presented in three general groups. First, a discussion of the more general neurological topics; second, an account of the form of the nervous system and the functional significance of its chief subdivision in general, followed by a review of the architectural relations of the more important functional systems; third, the cerebral cortex and its functions. A brief summary of the more commonly used technical terms is published and in the text some of the more special topics which may be omitted if a briefer presentation is desired, are printed in smaller type. It is an excellent presentation for the beginner of a most difficult subject.

A Text-Book of General Bacteriology. By Edwin O. Jordan, Ph. D., Professor of Bacteriology in the University of Chicago and in the Rush Medical College. Sixth edition thoroughly revised. Octavo of 691 pages, fully illustrated. Philadelphia and London. W. B. Saunders Company, 1918. Cloth, $3.75 net.

In the sixth edition of Doctor Jordan's excellent work, the chapter on the pneumo-coccus has been entirely rewritten and that on the meningo-coccus extensively revised. New section on infectious jaundice, rat-bite fever, and trench fever have been added. This is a most excellent textbook on general bacteriology covering fully the fundamental principles and methods of laboratory work, yet without unnecessary elaboration which is so confusing to the beginner and which is so often met in works of this kind.

The fore part of the work is devoted to methods of studying bacteria, a general consideration of the subject, immunity and classification of bacteria. This is followed by chapters on each special group with final chapters on the bacteriology of milk and milk products, bacteria in the arts and industries, the bacteria of the air, soil and water, and the bacterial diseases of plants. An appendix has been added on the infectious diseases of doubtful or unknown causation.

The Medical Clinics of North America. Volume II, Number II. W. B. Saunders Company, Philadelphia and London. 1918. Price per year, $10.00.

The U. S. Army number (Volume II, Number II) of the Medical Clinics of North America has the following list of contributors: Major-General Wm. C. Gorgas; Major Walter W. Hamburger; Major Herbert Fox; Contract Surgeon W. G. MacCallum; Lieut. Col. Channing Frothingham; Major Edward H. Goodman; Major W. W. Herrick; Lieut. Morris H. Kahn; Major E. P. Joslin; Major Homer Gage; Major Harlow Brooks; Major F. W. Peabody; First Lieut. Jos. T. Wearn; Edna H. Tompkins; Major Lawrence Litchfield; Lieut. Col. Jos. L. Miller; Captain Frank B. Lusk; Major Jos. C. Friedman; Captain Warren T. Vaughan; Major Russell L. Cecil; Major Charles L. Mix; Major Donald J. Frick; Major J. M. W. Scott; First Lieut. Macy L. Lerner; Major Thomas D. Coleman; Captain Emmet F. Horine; Major Charles S. Williamson.

This is one of the most valuable numbers of this excellent series published. It is a splendid presentation of the immense amount of clinical material made available by the war, and the different papers relating to the recent epidemic of respiratory diseases should be in the hands of every practitioner.

SCOPOLAMINE - MORPHINE, SEMI - NARCOSIS DURING LABOR. By Wm. Osborne Greenwood, M. D. Oxford University Press, American Branch, 35 West 32d Street, New York. 1918. Price, $2.00.

We all remember a few years ago when the subject of "Twilight Sleep" was a popular one. Wonderful articles appeared in the popular magazines and spectacular ones in the medical magazines. Pictures of "Twilight Sleep Babies" were common in the daily newspapers. Women from all parts of the country went to Europe to undergo the treatment that was to relieve them of all the pains of childbirth. Doctors were expected to give the treatment regardless of previous training or surroundings. Some men used the treatment for self advertising and some because they were intimidated by their patients. Then came the reaction and a certain number violently condemned the treatment. Nobody took a middle stand. I remember when a newspaper man called and wanted my ideas. I tried to give him a common-sense view but it was too tame and he would not print it. I tried to tell him that there were very good points and that without knowledge and judgment scopolamine might do much harm. I could not make him understand, or perhaps he did not want to understand, and so my personal opinion has never been put into print. Up to the time I had six years of experience with scopolamine. I had tried a third drug with "Twilight Sleep" combination in order to lessen any evil effects by reducing the dose of scopolamine and morphine. The third drug was theoretically ideal for the purpose and harmless but practically unreliable. If I ever get a relizable product I'll try again.

The work under discussion is the most complete on the market—the broadest and the finest. The history of the subject mentions the many noted men who were interested and their methods. It gives the extremes of ideas and a conservative summing up. It gives the results of years of work. It gives the faults of technique by the various authorities. The technique of Gans is described in full and lack of fulfilling his requirements, which was quite general, was the main cause of failures. It shows just how large and how fine the technique must be in order to insure success and how really most cases can be handled successfully and without danger. These points I shall bring out in the following paragraphs.

The object of the treatment, the longer relief of pain during childbirth, has been the dream of many men since history began. Even the ancients tried drugs, suggestions, etc. The relief of pain must not be attended by a lessening of work nor ill effects of overdose. Therefore the fine memory tests without complete analgesia, the quiet surroundings, and even the behavior of the attendants were considered. The stage must be set completely before the material effects of the drugs can properly take place.

On the action of the drugs the book is good as far as it goes. The action, as far as the effect desired for an ideal case, is complete but like all the other articles is not complete on heart, skin, eyes, secretions, breathing center, etc. He does not compare these with atropine which is a commonly understood running-mate of scopolamine. He does not mention how erratic the drug might act if it were given to a mother with a toxaemia, acute fever, metal or alcoholic poisoning, hyperthyroidism or mental weakness. He speaks only of the action on healthy people. The time of action is well covered. It takes an hour and a half for scopolamine to act and the time of repetition advised is an hour or more. The dosage advised is good for he speaks of one hundred and fiftieth grain plus a sixth or eighth of morphine. The safe dose by my experience is one two-hundredth of a grain.

The contraindications, or conditions leading to selection of cases suitable for the treatment, is well covered. I will not go into detail here except to say that very few articles are anything but vague on this subject. If the patient is normal mentally and physically, if the labor is not too quick, and if it is long enough lasting that the patient can be put under the influence there is very little, if any, danger in the use of "Twilight Sleep."

All in all the book is the best on the market on the subject. Twilight Sleep is not out of existence but is still used by a few well known men in various parts of the world. It will come up again in the future with further refinement and more safety and the reading of this little work will prepare you to judge it.

R. W. R.

"Pat," said the doctor, "your case is a very peculiar and baffling one, and if you'll agree, I'd like to call in another physician. Two heads are better than one, you know."

"Oi agree," returned the willing patient. "Sure, th' felly must be worth seein'. Bring in th' doctor wid two heads!"

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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The Wisconsin Medical Journal, Official Publication

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Calumet	H. C. Krohn, New Holstein	F. P. Knauf, Kiel.
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Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
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Fond du Lac	C. W. Leonnard, Fond du Lac	D. N. Walters, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
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Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
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La Crosse	H. E. Wolf, La Crosse	Sara Nimocks, La Crosse.
La Fayette	J. C. Huhenthal, Belmont	H. O. Shockley, Darlington.
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Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
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Waukesha	J. H. Overbaugh, Hartland	S. B. Ackley, Oconomowoc.
Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	F. G. Connell, Oshkosh	H. W. Morgenroth, Oshkosh.
Wood	J. C. Hayward, Marshfield	Wm. Hipke, Marshfield.

SOCIETY PROCEEDINGS

DOUGLAS COUNTY.

The Douglas County Medical Society at its regular meeting on February sixth, passed resolutions urging the immediate construction of a new isolation hospital. A petition was drawn up, signed by every physician present, and presented to the city commission. Doctor W. E. Ground talked on "Empyema and Lung Abscess, as Met With in the Army". Doctor Ground has just returned from active service. Doctor L. A. Potter read a paper on "Pneumonia and Influenza".

JOHN BAIRD, M. D., *Secretary.*

EAU CLAIRE COUNTY.

The Eau Claire County Medical Society held its regular meeting March 3, 1919, at eight P. M., following a dinner at the Galloway Hotel. The following program was given: "Talk on Health Topics," by J. F. Farr; and "Right Abdominal Pain," by Dr. C. Midelfart.

The annual meeting of the Eau Claire Medical Society was held at the Galloway House, January 29. Doctor E. L. Mason addressed the meeting on "The Experiences of Camp Dodge in the Influenza Epidemic," and Doctor Seemann spoke of the Medical Corps work at Fort Riley. The following officers were elected: President, Dr. E. M. A. Sizer; vice-president, Dr. W. O. Seemann; secretary, Dr. R. E. Mitchell.

R. E. MITCHELL, M. D., *Secretary.*

FOND DU LAC COUNTY

Members of the Fond du Lac County Medical Society met after a dinner at the Palmer House, February 12th. "The Relation of Pathology and Symptomotology of Goitre" was the subject for the evening discussion. Doctor E. A. Smith read the paper and illustrated same with lantern slides.

D. N. WALTERS, M. D., *Secretary.*

MILWAUKEE COUNTY. MEDICAL SOCIETY

The Milwaukee County Medical Society held its regular meeting at the Hotel Wisconsin, Friday evening, February 14th. The following program was presented: "A Proposed Bill for Compulsory Physical Training in the Schools of the State," Mr. George Wittich, physical director of the Milwaukee public schools; "The Epidemic of Influenza at Jefferson Barracks, Missouri," (with lantern slide illustrations), by Dr. Louis M. Warfield.

DANIEL HOPKINSON, M. D., *Secretary.*

MILWAUKEE MEDICAL SOCIETY

The regular monthly meeting of the Milwaukee Medical Society was held in the rooms of the organization, Colby-Abbott Building, on February 25th. Brief talks on experiences in American army camps were given by Doctors J. J. Seelmann, P. A. Fox, W. G. Darling, A. J. Patek, J. D. Madison and C. A. Fidler.

OUTAGAMIE COUNTY.

The regular monthly meeting of the Outagamie County Medical Society was held at the Y. M. C. A. at Appleton and was well attended. A supper was served at 6:30 p. m., following this a business meeting was held, after which the literary program was opened with a talk by Lieut. C. G. Flanagan of Kaukauna who gave us his experiences from the time he reported at Camp until he was honorably discharged. Capt. V. F. Marshall followed and took the same course. Both talks were very interesting and instructive and well given and greatly appreciated by those present. A general discussion followed and many questions asked and much "wheat separated from the chaf". Another well spent two hours for Outagamie. Arrangements are being made for a joint meeting of Outagamie and Winnebago Counties at Neenah at which one or two outside men of repute will be asked to be our guests and enlighten us.

GEO. T. HEGNER, M. D., *Secretary.*

RICHLAND COUNTY

The Richland County Medical Society met on January 30, 1919, and re-elected the old officers for the ensuing year. The war almost disrupted our membership. Doctors C. F. Dougherty, Gideon Benson, F. W. McKee and P. G. Lasche were all captains. Doctors Ainsworth, H. C. McCarthy, C. F. Breeden, and E. A. Parke were lieutenants. Doctors Dougherty, Benson, and McKee have been discharged. As has Lieutenant E. A. Parke of Viola, and they are all again at work. Lasche, McCarty, Breeden and Ainsworth are in France. We have good reports from all of them.

We hope to have regular monthly meetings for the ensuing year. Doctors Coumbe and Davis were admitted to membership at our last meeting. We all like the Journal and hope to be able to use some of its space this year.

R. H. DELAP, M. D., *President.*

SHEBOYGAN COUNTY

The annual banquet of the Sheboygan County Medical Society was held in the city of Sheboygan, January 17, 1919. The following officers were elected: Dr. Edmund Knauf, president; Dr. Edward Felter, vice-president; Dr. Harry Heiden, secretary and treasurer; Dr. O. B. Bock, delegate; Dr. T. J. Gunther, alternate, and Dr. H. C. Reich, censor.

HARRY HEIDEN, M. D., *Secretary.*

WAUKESHA COUNTY

The Waukesha County Medical Society held its annual meeting at the Majestic Hotel in Oconomowoc, February fifth. Several addresses were given by physicians returned from the government service. The following officers were elected: Dr. Overbaugh, Hartland, president; Dr. Nixon, Brookleld, vice-president; Dr. Ackley, Oconomowoc, secretary.

S. B. Ackley, M. D., *Secretary.*

WINNEBAGO COUNTY

The Winnebago County Medical Society held its regular monthly meeting in the Elk's Club, Oshkosh, February 26, at eight P. M. Dr. C. H. Nims addressed the society on "Empyema", illustrating the talk with lantern slides. A committee of the society was appointed to investigate and report to the mayor on a successor to Doctor A. H. Broache who has resigned as city health commissioner.

H. W. Morgenroth, M. D., *Secretary.*

ASSOCIATION NEWS

CONFERENCE ON INDUSTRIAL SURGERY.

Half a day is to be given the Industrial physicians and surgeons at the second Industrial Conference to be held in Milwaukee on April 28, 29 and 30, for a discussion of medical and surgical problems in industrial work. Two papers will be presented; one by a physician and one by Mr. Wilcox of the Industrial Commission. Mr. Wilcox will outline the ideals and aims of the Industrial Commission under the present law as it applies to the medical profession. A complete program will be published in the April issue.

WISCONSIN SURGICAL ASSOCIATION.

The Wisconsin Surgical Association will hold its annual clinical session in Milwaukee on Wednesday and Thursday, May seventh and eighth. Members of the State Medical Society are invited to attend these clinics. A preliminary program will be published in the next issue of the Journal.

Daniel Hopkinson, M. D., *Secretary.*

CORRESPONDENCE

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE.

MENTAL HYGIENE WAR WORK COMMITTEE.

February 10th, 1919.

Rock Sleyster, M. D.,
Waupun, Wisconsin.

Dear Dr. Sleyster:

We would urgently call your attention to, and consideration of the enclosed suggestions of standard forms for laws pertaining to the welfare of persons suffering from mental or nervous disorder. We have forwarded like copies to the Governor of your State, asking that he submit these forms to the Legislative Assembly, that they may aid in creating necessary legislation, which we think, should be made that help may be contributed to many Soldiers now returning to civilian life who present problems in mental or nervous disorder needing prompt and scientific care.

The object of these suggested laws is to encourage easy access to hospital care, early first-aid, intelligent over-sight and scientific treatment of mental or nervous disorders occurring in discharged soldiers and other persons, divesting the procedure of hospital entrance of the usual cumbersome formalities which have been a hindrance to the recognition of the fact that such disorders are medical rather than legal problems. The term insanity is now recognized as only of legal significance and should be used only as a legal term.

The National Committee for Mental Hygiene believes that never before has there been such an opportunity to present the need of better laws giving more consideration to mental and nervous disorders as essential medical problems based on the broad humanitarian principles that prevention is better than cure and that cure is better than chronic invalidism. As an economic measure, prevention in mental disorders is a policy that every State should adopt. It is due the State as a saving in dollars and cents and it is due the patients in the benefits to be derived in prevention of a mental disorder, in making possible early first-aid care of all persons needing the benefits of hospital facilities.

These forms are drawn with a view of giving hospital advantages to the patient without the stigma of having been adjudged insane in its legal application. To the discharged soldier this is of the utmost importance and is a duty each State owes to the defenders of our national liberty, likewise to other persons. This privilege should be extended to be in keeping with the modern conception of mental disorders as disease, which means much to the peace of mind, status of citizenship and the social welfare of the individual and his family. Your State may have laws covering these essential needs, but in view of our endeavor to standardize and promulgate the broad conception of laws in keeping with the medical ideals of service, we urgently ask that the laws of your state pertaining to the care and treatment of the insane be carefully reviewed. Also, that they be revised in keeping with the lessons which this great war has brought home to every State; lessons emphasizing well-known truths that physicians have long since known, but to which the public gave little thought, until they became popularized through the observational studies of the Army and Navy,—the lessons that mental disorders should be early recognized and the rights of the patient conserved.

We enclose you also a copy of a report on the application of War Risk Insurance to mental and nervous invalids, which will aid you in presenting the claims of the Soldier in economic terms, showing the State officials the responsibility to be born by the War Risk

Insurance Bureau. May we ask that you interest yourself and others in this needed legislation? It may be necessary in order to present the facts of this progressive legislation to the General Assembly, that you and others constitute yourselves as emissaries to be present at hearing before the Committees.

The National Committee for Mental Hygiene would bespeak your co-operation and helping hand in furthering this welfare work much needed throughout this Country.

Very respectfully yours,

COMMITTEE ON LEGISLATION,
Dr. George M. Kline, Chairman.

Suggested standard forms of laws for the observation, emergency commitment, temporary care, and voluntary commitment of persons needing care and treatment because of mental disorder. The establishment of community service in state institutions for mental and nervous disorders, etc., etc.

NOTE.—Before any of the forms, herewith suggested, are introduced as bills, they should be carefully examined by an attorney in the State concerned, in order that such changes may be made therein as will bring them into harmony with the legal usage and procedure in the State.

OBSERVATION AND CARE.

If a person is found by two physicians qualified as examiners in insanity to be in such mental condition that his commitment to an institution for the insane is necessary for his proper care or observation, he may be committed by any judge or any other officer authorized to commit insane persons to any state, private or incorporated institution for the insane under such limitations as the judge may direct, pending the determination of his insanity.

EMERGENCY COMMITMENT.

The superintendent or physician in charge of any institution public, private or incorporated, to which an insane person may be committed, may, without an order of a judge (or insert any other committing magistrate), receive into his custody and detain in such institution for not more than ten days, any person whose case is certified to be one of violent and dangerous insanity or of other emergency by two physicians, duly qualified as examiners in insanity, by a certificate conforming in all respects to the provision of law required in a medical certificate of insanity, and said certificate may, if the commitment of such person as insane shall be duly completed, be used as the certificate of insanity required by law. The officers required by the laws of commitment of the insane, or any member of the state or district police shall, upon the request of the applicant or of one of the said physicians, cause the delivery of such alleged insane person to such superintendent or physician. The person applying for such an admission shall within ten days cause the alleged insane person to be duly committed as insane or removed from the institution and, failing thereof, be liable to the institution for the expense incurred and to a penalty of fifty dollars which may be recovered by the institution by an action of contract.

TEMPORARY CARE.

The superintendent or physician in charge of any institution public, private or incorporated, to which an insane person may be legally committed, may when requested by a physician, by a member of a Board of Health or by a health officer, by an authorized agent of the State Board of Insanity, by a police officer of a city or town or by a member of the state or district police, receive and care for as a patient in such institution for a period not exceeding ten days, (or fifteen days), any persons who needs care and treatment because of his mental condition.

Such request for admission of a patient shall be in writing and filed at the institution at the time of the reception of the patient, or within twenty-four hours, thereafter, together with a statement in a form prescribed or approved by the State Board of Insanity (or insert the proper title of the State Supervising Board) together with a statement giving such information as said Board may deem appropriate.

Such patient who is deemed by the superintendent or physicians not suitable for such care shall, upon the request of the superintendent or physician, be removed forthwith from the institution by the person requesting his reception and, if he is not so removed, such person shall be liable for all reasonable expenses incurred under the provisions of this act on account of the patient, which may be recovered by the institution in an action of contract.

Said superintendent or physician shall cause every patient to be duly committed according to law, provided he shall not sign a request to remain as a voluntary patient, or to be removed therefrom before the expiration of said period of ten days.

All reasonable expenses incurred for the examination of the patient, for his transportation to the institution and for his support therein, shall be allowed, certified and paid according to the laws providing for similar expenses in the commitment and support of the insane.

VOLUNTARY COMMITMENT.

The superintendent or physician in charge of any institution public, private or incorporated to which an insane person may be committed, may receive and detain therein as a boarder and patient any person who is desirous of submitting himself to treatment, and who makes written application therefor, and whose mental condition in the opinion of the superintendent or physician in charge is such as to render him competent to make the application. Such superintendent or physician shall give immediate notice of the reception of such voluntary patient to the State Board of Insanity (or insert the proper title of the State Supervising Board).

Such patient shall not be detained for more than ten days after having given notice in writing of his inten-

tion or desire to leave the institution.

The charges for support of such voluntary patient shall be governed by the laws or rules applicable to the support of an insane person in such institution.

COMMUNITY SERVICE.

SECTION 1. Every state institution, to which an insane, feeble-minded, or epileptic person may be committed, shall appoint a physician experienced in the care and treatment of such persons, also the necessary assistants to such physician, and shall organize and administer under his direction a department for community service in the district served by the institution. The duties of said department shall be:

First—The supervision and assistance of patients who have left the institution with a view to their safe care at home, suitable employment and self support under good working and living conditions, and prevention of their relapse and return to public dependency.

Second—Provision for informing and advising any indigent person, his relatives or friends and the representatives of any charitable agency, as to the mental condition of any indigent person, as to the prevention and treatment of such condition, as to the available institutions or other means of caring for the person so afflicted, and as to any other matter relating to the welfare of such person.

Third—Whenever it is deemed advisable the superintendent of the institution may co-operate with other State Departments such as Health, Education, Charities, Penal, Probation, etc., to examine upon request and recommend suitable treatment and supervision for

(a) Persons thought to be afflicted with mental or nervous disorder.

(b) School children who are nervous, psychopathic, retarded, defective or incorrigible.

(c) Children referred to the Department of Juvenile Courts.

Fourth—The acquisition and dissemination of knowledge of mental disease, feeblemindedness, epilepsy and allied conditions, with a view to promoting a better understanding and the most enlightened public sentiment and policy in such matters. In this work the department may co-operate with local authorities, schools and social agencies.

SEC. 2. The necessary expenses of said department shall be paid from a special appropriation for this purpose not exceeding * * * dollars, subject to the approval of the Supervising State Board or Boards.

CONVEYING PATIENTS TO THE HOSPITAL.

The judge or magistrate of the court may appoint a proper person to convey the patient to the hospital. If a woman is committed to an institution under the supervision of the State Board or Commission, the committing judge or magistrate must, unless she is accompanied by her father, husband, brother or son, designate a woman of reputable character and mature age to accompany her thereto.

PAROLE AND DISCHARGE OF PATIENTS.

The superintendent of a state hospital may grant a parole to a patient under regulations prescribed by the State Board or Commission, for a period not exceeding one year, and may receive said patient again when returned by the proper authorities, relatives or friends, or upon personal application of the patient within this period without a new commitment.

REPORT ON WAR RISK INSURANCE.

The emergency arising from demobilization of the army has precipitated a great problem in hospitalization upon the U. S. Government. The present hospital facilities under the control of the Government are inadequate to meet its present or prospective needs in caring for mental or nervous invalids. It will, therefor, be necessary that the State, incorporated and private hospitals be utilized to meet the demand thus created. It is hoped that mental or nervous patients will be sent to hospitals as near their homes as possible. To contribute to this possibility, the State incorporated and private hospitals, must be depended upon to do their full duty in providing treatment and care of the patients during this emergency and until such time, when the U. S. Government can build hospitals of its own.

The War Risk Insurance will pay for the maintenance, treatment and care of patients in the State, incorporated and private hospitals, to the extent of the allotment under arrangements made by the War Risk Insurance. This payment is at the rate of two dollars and fifty cents ($2.50) per day. The state, incorporated and private institutions will be called upon to provide a space as above mentioned, needed, and the War Risk Insurance will pay the rate as above stated, although the relatives, friends, guardians or others in authority in the affairs of the patient may make personal arrangements with state, incorporated and private institutions to pay an additional amount for the treatment and care of patients in these institutions, the amount to be paid is to be a personal agreement with and paid for by the relatives, friends or guardians of the patients.

It must be remembered that the War Risk Insurance deals only with discharged soldiers, and only such as have applied for compensation under the act. Further, that the War Risk pays only and cares for the particular disability for which the soldier was discharged, therefore the soldier is charged with the necessity of making application for compensation and this must be done within the year. However, if the soldier breaks down within three years, he may make application.

Inasmuch as most of the soldiers are unaware of the privilege that is offered them to make this application, and many already are in the care of state hospitals and other institutions, it is necessary that publicity be given to the fact that these discharged soldiers are entitled to compensation, for, this reason The National Committee for Mental Hygiene or other Social Agency will be called upon to act as an intermediary, to notify the superintendent of state, incorporated and private hospitals, that

discharged soldiers who may come under their care are entitled to this compensation, and, therefor, these superintendents or managing officers should notify these discharged soldiers of their rights. Furthermore, where there are no relatives, guardians or other agents to act for a discharged soldier, The National Committee for Mental Hygiene or other Social Agency may undertake to make these applications for these discharged soldiers.

The Government's position is to treat these patients, in other words, the Government's interest is in treatment of the case, to get the discharged soldier well, and to restore him to his earning power. This Act should not be construed as a pension, it is a compensation which stops on recovery of the patient, but if the patient again becomes ill of the disability for which his claim was originally made, he can again come under treatment. The Government must provide on the state, incorporated and private hospitals to do their duty in providing treatment and care of the discharged soldiers during the emergency and until the Government can build its own hospitals.

Caution should be exercised in making the final discharge of the patient when it is thought he has overcome his disability, because compensation ceases then. But, as before stated, should the disability recur, the soldier is again entitled to treatment. The insurance continues as annuity in the event that the soldier is totally disabled and cannot again develop earning power. Where total disability occurs, the manner and form of

War Risk payments will be on the following order:

1. That the soldier will receive compensation.
2. He will receive treatment and care.
3. His family will receive the annuity.

This Act as applied to the Neuro-psychiatric Division will cover cases:

1. Insane.
2. Epileptics.
3. Other neuroses while under care and treatment.
4. Neurological cases with organic lesions.
5. Miscellaneous group.

The total number of discharged soldiers can not even be estimated. It is known that there are five thousand epileptics now on the books, and a large number overseas. There are over one thousand cases of war neuroses being treated at Plattsburg. The number overseas is not known definitely. The Government, under the War Risk Act, will assume responsibility for the care and treatment of these cases. Also, it is proposed that the Government will have an epileptic colony for the care of epileptics. It must be remembered that these epileptics can not be forced to go to this colony, as it will be purely voluntary, and soldiers, or civilians after discharge, and as the War Risk can only begin to act after the soldier is discharged, there will be no authoritative power over the epileptic patient to compel him to go to the Government epileptic colony. The soldier, however, can draw compensation even if he refuses treatment. This, of course, to be under inspection of the Government. If, however, the patient first declines hospital care because he only has say 25% disability and later should show greater disability, he may come under the protection of the Government, but cannot claim any increased disability. The Government will have inspectors to investigate the treatment and care of patients in all institutions receiving payment from the War Risk Insurance.

It is therefore advised that attention be given toward improving state laws governing voluntary admission to institutions caring for mental cases. Inasmuch as it is a fact that the soldier cannot be compelled to enter a state, incorporated or private hospital, voluntary, it will be necessary that the social agencies in different communities be used to present the advantages of hospital care to discharged soldiers and their relatives, in order that they take advantage of this Voluntary Commitment Act. This likewise will pertain to such hospitals as the Government itself may establish, especially the epileptic colony. Where it is necessary that the patient be committed in order to comply with legal conditions involving property rights, the patient's relatives or agents should be informed, in order that the individual rights of the patient and his family may be conserved.

Committee,

Dr. Owen Copp,
Dr. Frank P. Norburg,
Acting Medical Director,
National Committee for Mental Hygiene, New York City.

NEWS ITEMS AND PERSONALS.

Governor Philipp has appointed Doctor J. S. Evans, head of the Clinic at the University of Wisconsin, as a colonel on his staff.

The Governor has also appointed Doctors Edwards S. Hayes of Eau Claire and W. H. Whyte of Madison to succeed themselves on the State Board of Health.

Doctor Rock Sleyster, superintendent of the Central State Hospital for the Insane, has resigned his position to take charge of the Milwaukee Sanitarium at Wauwatosa. He will assume his new duties March fifteenth.

At a meeting of the board of directors of Mercy Hospital, Janesville, it was unanimously decided to build an addition large enough for at least forty more beds and to start construction this spring.

Doctor J. P. Lenfesty has been re-elected president of the De Pere Health Association.

The annual report of St. Joseph's Hospital, Chippewa Falls, shows a total of 3144 patients admitted during 1918.

Health Commissioner Ruhland of Milwaukee has recommended to the Council that the Blue Mound Sanitorium and Preventorium be taken over by the county.

Doctor and Mrs. N. M. Kersten of De Pere are making an extended visit in the south. Dr. D. F. Gosin of Green Bay is looking after his practice while he is away.

Doctor R. B. Quinn of Darlington is taking post-graduate work in Chicago and on his return will establish an independent office. He formerly practiced with Doctor W. W. Peck.

The Supreme Court has affirmed the decision of the lower court in the case of John Till who has been operating as a "plaster doctor" near Turtle Lake. The district attorney brought a charge of practicing without a certificate of registration against him. Till was found guilty November 28, 1917, and sentenced to pay a fine of two hundred and fifty dollars. He appealed the case.

Doctor and Mrs. R. G. Sayle of Milwaukee have gone to St. Petersburg, Florida, for the remainder of the winter.

Doctor P. F. Gaunt of Oconto has sold his home and removed to Milwaukee.

Doctors Voight and Was of Oostburg had a narrow escape from serious injury on February third. Their buggy collided with a vehicle driven by a farmer and Doctor Voight was thrown to the ground but sustained only minor injuries.

Dr. E. M. A. Sizer of Fall Creek has located in Eau Claire.

Doctor George Ribenack who has been associated with Doctor W. O. Seemann of Eau Claire since last summer has located in Bloomer.

Herman C. Lemke of Milwaukee, charged with putting labels containing false statements on patent medicine, was recently fined three hundred dollars.

Doctor W. A. Evans of Chicago was the principal Speaker at the annual meeting and dinner of the Madison General Hospital Association, on February eleventh.

Doctor J. N. Palt of Kenosha had an exciting experience with burglars February ninth. The intruders were routed by Doctor Palt who was at the trigger end of a double gage shot gun.

The Stober Maternity Hospital of Madison has been taken over and will be operated by the First Methodist Episcopal Church. The church has purchased all equipment and will continue work with the same force.

Doctor G. H. Lawrence, who has been recently discharged from the service and formerly practiced at Fond du Lac, has located in Stevens Point where he will limit his practice to diseases of the eye, ear, nose and throat.

The nurses of Trinity Hospital, Milwaukee, gave their annual dance at the Knights of Columbus hall, February 18th.

Doctor P. G. McCabe of Dotyville has located in Fond du Lac. Doctor McCabe has recently been discharged from the service.

Doctor James Lyons, for many years a practicing physician at Bear Creek, submitted to the amputation of his left arm at St. Elizabeth's Hospital, Appleton, January 30th. The amputation was the result of an infection following injury. Doctor Lyons has been attending to the practice of Doctor Eugene Gates of Tigerton during Dr. Gate's army service.

Dr. Harry Shearer has located at Edgerton and is associated with Doctors Ansley and Floyd Shearer.

T. L. Peterson, a transient patient of John Till, the plaster artist at Turtle Lake, died at the Till Hotel February 14th. The coroner's inquest found that death was due to infection caused by the blister the plaster made on Peterson's back. The county authorities will investigate.

Doctor M. A. Flatley of Antigo is taking post-graduate work in Chicago.

Doctor William Jobse of Milwaukee has filed nomination papers to make a race for school director in the April election.

Dr. J. P. Zohlen of Sheboygan has left for New York to take a three month's post-graduate course.

Capt. O. H. Foerster, Milwaukee, has been discharged from military service and has resumed his practice.

At the January Session of the Wisconsin State Board of Medical Examiners, held at Madison, Wis., twenty-one candidates were examined, one of whom failed. Three were licensed by reciprocity and two on presentation of honorable discharge from the Army or Navy. Of those examined, schools represented, were as follows:

Marquette University, 13.
University of Michigan, 3.
Rush Medical College, 3.
Jefferson Med. Coll. of Phila., 1.
American School of Osteopathy, 1.

Members of the Fond du Lac medical profession were entertained at a seven o'clock dinner by Doctor F. S. Wiley, February 21st, the occasion being the celebration of the doctor's thirty-sixth anniversary in practice. Covers were laid for twenty-five physicians. Dr. J. B. Darling of St. Paul was the only out of town guest. As a remembrance of the occasion, Doctor Wiley was presented with a handsome electric clock.

Senator Skogmo has introduced a bill into the legislature to accord recognition to Christian Science under the workmen's compensation act.

Patrick Cudahy of Milwaukee has endowed the Marquetted Medical School dispensary with $133,000. Thirty-three thousand was left to the dispensary by the will of the late Helen Cudahy. As a token of appreciation, the dispensary has been dedicated to Miss Cudahy's memory and will be known as the Helen Cudahy Memorial Dispensary Clinic.

Doctor A. H. Broache has tendered his resignation as health commissioner of the city of Oshkosh. The Winnebago County Medical Society has been asked to help in the selection of a successor.

Doctor Francis A. Malone of Waterford, while conveying a patient to Mt. Sinai Hospital, Milwaukee, collided with a car driven by Mr. Barney B. Weber, February 8th. The impact of the collision threw Weber out of his machine while Doctor Malone's car upset, pinning the occupants beneath it. Mr. Weber was instantly killed and the others all more or less seriously injured.

The Wisconsin Industrial Commission is urging the passage of the Benfey bill which brings occupational diseases under the workmen's compensation act.

Doctor W. B. Campbell, formerly of Menomonee Falls and recently discharged from the government service, has located in Waukesha.

Doctor R. L. MacCormack who has been recently discharged from the service, has located in Janesville and will occupy the former office of Doctor W. A. Munn.

The Martin Luther Hospital Association of Superior is making plans to build a new hospital soon and a campaign for funds for the work will be launched in the near future. The plan to build a new hospital was well started when the United States entered the war but was temporarily abandoned.

The Harrison Act, as amended by the new War Revenue Act, will be mailed postpaid to any druggist, physician, dentist or veterinarian who will send a postal request therefor to "Mailing Department. Parke, Davis & Co., Detroit, Mich." Please observe direction strictly.

A Joint Influenza Committee has just been created to study the epidemic and to make comparable, so far as possible, the influenza data gathered by the Government departments. The members of this committee, as designated by the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, and the Director of the Census, are: Dr. William H. Davis, chairman, and Mr. C. S. Sloane, representing the Bureau of the Census; Dr. Wade H. Frost and Mr. Edgar Sydenstricker, of the Public Health Service; Colonel D. C. Howard, Colonel F. F. Russell, and Lieutenant Colonel A. G. Love, United States Army; Lieutenant Commander J. R. Phelps and Surgeon Carroll Fox, United States Navy.

K. D. Shastri, representative from India to the world's fair at San Francisco, misrepresented his ability to Edward Roessler, rich La Crosse county farmer, so that he could get $50 a day from him for treating his insane wife, according to a verdict returned in circuit court here. Shastri claimed to be a psycho-therapist and treated Mrs. Roessler. She is still insane. Roessler will get back his draft of $950 given to the Hindu.

Dr. G. R. Duer of Halstead, Kans., has begun to practice in Stoughton with Dr. W. L. Wentzel, whose practice and home he purchased. Dr. Wentzel and Dr. Duer will be associated until the former, with his family, leaves for a vacation in the west in the late spring.

Dr. Mary Walker, 87 years old, died at her home near Oswego after a long illness. She was a surgeon in the Civil war and was awarded a congressional medal of honor. She gained considerable fame by being the only woman allowed to appear in male attire by an act of congress.

Changes in the rule for quarantine of diphtheria cases to give more protection to exposed persons are ordered by the state board of health. Persons exposed to or in the family with the patient must be quarantined, and may not be released until a culture from both the nose and throat shows absence of the diphtheria bacilli, and after disinfection of person and clothing. Children remaining in the home with a patient under quarantine can not return to school until five days after one negative culture has been obtained from both the nose and throat and the quarantine removed; such culture to be taken at the time the release cultures are taken from the patient. Children exposed to or in the family with the patient may return to school providing one negative culture has been obtained from the nose and throat and the children have taken up their residence elsewhere for five days. Contacts not in the family with the patient may return to school after one negative culture has been obtained from both the nose and throat. The scarlet fever rule, also amended, now provides a three weeks' quarantine and until the mucous membrane of the patient is again normal or complete desquamation of the skin occurs.

Statistics for 1918 of the Milwaukee Children's hospital indicate that 758 cases have been taken care of by the hospital proper and 11,239 visits (children examined) were paid by the out-patient department. Most of the children came from poor families or from families where the fathers were out of work.

Compulsory health insurance legislation is not favored by the special legislative committee appointed by the last session of the legislature to investigate the problem in Wisconsin. The majority of the committee has filed a report against the plan. It recommends preventive health measures, which it declares will accomplish more by an expenditure of $1,000,000 than $20,000,000 would under a strictly health insurance law.

The committee was composed of Senators W. W. Albers, Wausau; Theodore Benfey, Sheboygan; Assemblyman John Donnolly, Milwaukee; W. L. Smith, Neillsville and Henry Ohl, Jr., Milwaukee. All members with the exception of Ohl join in the majority report against the health insurance system.

More than 1,500,000 children have been weighed and measured since the "Children's Year" campaign to save lives lost from preventable diseases was inaugurated by the children's bureau. Wisconsin has returned more cards than any other state, a total of 166,000, or about 65 per cent of the state's population under 5 years of age. Indiana, Minnesota and North Dakota have returned cards for more than one-third of their children.

The new county hospital for Milwaukee may be modeled after the Emergency hospital in Washington, D. C. The delegation of supervisors, headed by Chairman W. E. McCarty and accompanied by Architect A. C. Clas, which is visiting the hospitals of the east to gain ideas for Milwaukee's new medical institution, was highly impressed with the Emergency hospital in the capital and gave it thorough study.

Quackery in connection with the treatment of veneral diseases among returning soldiers and sailors, the establishment of a prophylactic station in Milwaukee and the co-operation of physicians and druggists, were discussed at a conference which was attended by Dr. I. F. Thompson, a member of the state board of health, in the office of Health Commissioner George C. Ruhland.

The requested appropriations for capital improvements asked by the state charitable and penal institutions through the report of the state board of control to the legislature amount to $900,000. The following requests for capital improvements are made by the various state institutions: Northern Hospital for the Insane at Oshkosh, $45,700 this year and $1,700 next year; Delavan school for the deaf, $14,150 this year and $1,350 next; Janesville school for the blind, $12,650 this year and $2,250 next; Boys' industrial school at Waukesha, $17,150 this year and $5,600 next; Waupun state prison, $132,800 for this year and $1,500 for next; state public school at Sparta, $4,050 this year and $3,250 next; Chippewa Falls home for feeble minded, $1,750 for each year; Green Bay state reformatory, $31,400 this year and $5,400 next; Wales tuberculosis sanitorium, $2,775 this year and $3,275 next; central state hospital for insane at Waupun, $53,300 this year and $59,250 next; Tomahawk Lake tuberculosis camp, $9,850 for this year and $6,850 for next, Milwaukee industrial school for girls, $16,850 for this year and $500 for next; Union Grove home for feeble minded, $144,100 for first year and $120,100 for next.

The State of Wisconsin, working jointly with the federal government, has instituted more effective measures for the control of venereal diseases. The legislature this week was given an insight into the problem's seriousness, members witnessing the government's film, "Fit to Fight," shown under the auspices of the state board of health.

Wisconsin Social Hygiene Society, at the City Club, elected: president, M. C. Potter; first vice-president, Dr. G. A. Harlow; second vice-president, Judge E. T. Fairchild; third vice-president, Smith Y. Hughes; secretary, Dr. J. Van de Erve; treasurer, Mrs. John Joys; board of directors, M. C. Potter, Dr. G. A. Harlow, Judge E. T. Fairchild, Mrs. Julia Kurtz, Miss Amelia McMinn, Dr. George C. Ruhland, Dr. Philip Rogers, Smith Y. Hughes, Dr. J. Van de Erve, E. W. Schultz, Sheboygan.

Special Red Cross courses in nursing and hygiene are attracting many of the members of the girl's community service. The girls are instructed in ambulance work, for which an ambulance, fully equipped, has been provided. At the University Settlement, on First Avenue, there are two classes taking the course. There is one class each at the Abraham Lincoln House and at the Forest Home Social Center. The Anti-Tuberculosis Association has established a short course in nursing for the girl's community service, one unit meeting Tuesday night in the Grand Avenue Congregational Church, one Friday afternoon, one Tuesday night and another Thursday night.

Karl Windesheim, son of Dr. and Mrs. G. Windesheim who has been in the service of the navy board submarine chaser No. 25 off New London, has been discharged. He has been placed on inactive service and will remain in Kenosha indefinitely subject to his being called back to the navy for service.

A bill introduced in the Indiana legislature provides that in every county having more than 10,000 poulation there shall be a county health commissioner to be appointed by a board consisting of the county auditor and county superintendent of schools. The bill further provides that the health officers shall give their entire time to the duties of their office, and shall not engage in private medical practice or engage actively in any other business. It is provided that the health officers shall have statutory powers of a constable in all matters pertaining to public health, and in the enforcement of health laws, ordinances, rules and orders of the state board of health.

Dr. V. A. Gudex of Milwaukee, who during the war was employed by the United States public health service as an assistant surgeon in different localities of the state during the influenza epidemic, was appointed deputy state health officer by the Wisconsin state board of health. He will have charge of the fourth district comprising several counties in the western part of the state. His headquarters will be at Eau Claire.

Twenty-four thousand soldiers have been discharged from the army as tubercular since the beginning of the war, the senate buildings committee was told by Dr. W. G. Stimpson of the United States public health service. He said the history of tubercular patients indicated that they would be in the hospitals one-third of the time. Tentative plans of the public health service for adding 2,000 beds to existing hospitals were described.

Deaths in Wisconsin during 1918 were 34,469, representing an annual death rate of 13.6 per thousand, which is more than three per thousand higher than any rate ever recorded in the state. This fact, says the annual mortality report, is due entirely to the influenza epidemic during October, November and December which, exclusive of the usual incidence of pneumonia and influenza, exacted a toll of more than 7,000 Wisconsin lives. Of these two disease 102,733 cases were reported during the year.

DEATHS

Doctor L. G. Armstrong, pioneer resident of Grant County, for over 52 years an honored citizen and prominent physician of Boscobel passed away at his home February first. He practiced medicine for six years at Fennimore, from 1860 to 1866. He moved to Boscobel in 1866 and had an enviable reputation as a physician in that part of the state. He was also prominent in school circles, having been clerk of Boscobel public schools for over 40 years and a member of the Grant County Board of Education. He was past 84 years of age, born March 8, 1834. He was a member of Grant Lodge number 169 and De Molai Commandary number 15, Knights Templar of the Masonic order. Funeral services were held under the auspices of the above orders. Doctor Armstrong was a member of the Grant County, Wisconsin State, and American Medical Associations.

Doctor Guy C. Bowe, age 53, former practicing physician at Fond du Lac, died at his home in Cleveland, Ohio, February third. He left Fond du Lac some years ago for Virginia, subsequently moving to Cleveland where he has lived since.

Doctor John Dwight Freeman of Topeka, Kansas, formerly a resident of Madison and a son of the late Professor John Dwight Freeman of the University, died at his home in Topeka, January 27th. Doctor Freeman, universally known as "Buck" Freeman, was one of the most popular students in the University a quarter of a century ago.

HEALTH ALMANAC.

One of the almanacs of the 16th century bore the following title:

"Pronostycacyon of Mayster John Thybault, medycyner and astronomer of the Emperyall Majestie, of the year of Our Lorde God MCCCCCXXXIJ., comprehending the iij partes of this yere, and of the influence of the mone, of peas and warre, and of *the sykenesses of this yere*, with the constellacions of them that be under the vij planettes, and the revolucions of Kunges and princes, and of the eclipses and comets."

We are still prognosticating on the subjects of "peas and warre, and the revolucions of Kynges and princes," but the United States Public Health service in its *Health Almanac for 1919* is not content with chronicling our various ills, but preaches prevention of the "sykenesses of this yere."

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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DISEASE AND WATER.

The greatest movement today is the prevention of disease. Means and methods for the prevention of both bacterial and non-bacterial disease are being investigated and understood. For the purpose of discussing water as a means of spreading disease, I will confine myself first to a general discussion of bacterial diseases in order that water as a means of spreading these diseases may be better understood, and secondly the discussion of water in order that the two, bacterial diseases and water supplies, may be linked together, and both viewed from the point of disease prevention.

BACTERIAL DISEASES.

All bacterial diseases are communicable. I I mean by that that any disease which is caused by bacteria can be passed along to someone else provided a means of transfer is afforded. Disease producing bacteria are very small objects but they have a physical existence. They have size, shape, weight. In order therefore for bacteria to get from one person to another it is necessary that they come in contact with some object or be caught up on or in some substance upon which or in which they can be transferred. To illustrate what I mean, tubercle bacilli may be conveyed from one who is coughing them up to another by hand shaking or on handkerchiefs. Typhoid bacilli may be passed from one to another by hand shaking, on soiled linen, or in water.

Some bacteria produce disease in the lungs, throat, mouth and nose, and of course the secretions, sputum, saliva, etc., from these cases contain the disease producing germs.

Other bacteria produce disease in the intestines, in which case the discharges from the bowels and sometimes the bladder carry these disease producing germs.

The question is: What part does water play in carrying germs from one person to another? In order to answer this question it will be necessary to consider how disease producing germs may get into water or utensils used in conveying the water.

The Massachusetts State Board of Health has classified water as normal and polluted, the former being free from the addition of sewage or industrial waste either directly or indirectly. The term sewage is here used to mean any house wastes or surface washings from areas densely populated.

The source of supply, surface water, or deep underground water, often determines whether the water is safe to drink. Rain water constitutes a large part of the supply of drinking water in some sections and is usually collected from the roof of the house and stored in underground cisterns. These cisterns are situated as a rule very close to the house and may be in close proximity to outhouses and frequently are not well covered or protected above the gound so that during rainy seasons surface water seeps into or actually washes over the top into the cistern. In such communities outhouses are frequent and human excreta is nearly always a part of surface washings. All surface water in areas of human habitation are unsafe for drinking purposes without some sort of treatment. Then there are other surface waters, springs which are fed by surface washings and particularly those which emerge at the foot of hills. Shallow wells, rivers and lakes, both of which receive water which is more or less polluted, are counted as surface water and are not safe to drink as a rule without treatment.

It is not an uncommon sight to see, particularly in farming sections, a shallow well which is poorly covered over the top situated close to the dwelling house, outhouse or barns and where the drainage is in the direction of the well. The water supplied from such wells are always highly polluted, containing a large number of bacteria and other objectionable material. The washings which go into such a well drain directly from deposits of human excreta, feces, etc., and referring to the first part of the discussion, disease producing bacteria from the intestinal tract are shed in and contained in this excreta. It is not astonishing then that people using water so polluted should be frequently troubled with diarrheal diseases, typhoid fever, and other intestinal and digestive complaints.

While the pollution of surface water with disease bacteria is so frequent and such an important consideration, it is not all. Surface polluted water may contain other injurious matter. It has been found that in communities where highly polluted water is used the people are not only frequent sufferers from the diseases which are spoken of as water borne diseases, typhoid, dysenteries, etc., but are actually more susceptible to other diseases which can not be said to have been gotten by drinking the disease forming germs in the water. This interpreted means, of course, that regularly drinking water which is polluted lowers the vitality and therefore renders the body less able to resist disease.

Wells used as the source of supply for drinking water should be well protected by concrete covers and should be situated a considerable distance from dwellings, outhouses and barns and in a position so that the drainage is away from the well and not toward it.

Water which is obtained from deep wells, which are properly protected, are usually free from disease producing bacteria and other matter deleterious to the health. It usually reaches the surface in a pure state except from some unusual circumstance. If then the water at its source of supply is pure or has been made by treatment safe for drinking water, it then remains to get it to the people free from pollution or contamination.

Because of the concentration of people in great industrial centers, the extensive travel on railroads or automobile, and the close association of large numbers of people for many purposes, the question of the spread of disease is not wholly confined to the water at its source of supply, but also with the means by which each individual obtains a drink.

The water supply at its source is usually responsible for the spread of such diseases as typhoid, cholera, and dysentery, which can be accounted for by a pollution of the supply with human excreta. Other diseases, syphilis, diphtheria, tonsillitis, pneumonia, are spread not by the water but in the mouth secretions and sputa of people who are carrying the germs which cause these diseases in their nose, throat or mouth. The old community or common drinking cup was and still is one means by which these diseases are spread.

In factories, railroad stations, and on railroad trains, it has not been so long since it was the rule to see a tin cup tied to the water cooler, and everybody was invited to come and have a drink from the same cup. This cup was used by the sick and well; by those who had syphilis and by those who did not. The man with syphilis at some time during the disease usually has sores in his mouth. These sores grow from small ulcers in the throat and mouth to large ulcers which involve the inside of

the cheeks, the gums and the tongue. The sores are open, that is, raw, and the saliva and secretion from the mouth of such a person carries the germ which causes syphilis. When he or she drinks from the common drinking cup there is deposited around the side of the cup saliva from the mouth. Sometimes indeed the cup dips into or rubs into the sore and some of the dead tissue always lying loosely on the surface is left on the side of the cup. The next person who drinks puts into his or her mouth the same cup, rubs the infected surface maybe on a crack in the lip or a small sore on the tongue and as a result they have syphilis. It is therefore plain how the common drinking cup serves to transfer disease from one mouth to another.

In order to prevent this means of spreading disease many new and ingenious methods have been devised to distribute drinking water. Individual drinking cups made of paraffin paper are frequently seen. These individual cups are the very best means afforded to obviate the dangers of the common drinking cup. They come in envelopes of wax paper. The envelope insures cleanliness and freedom from contact with the hands of those who sell or dispense them. They can be bought very cheaply. The traveler or other person drinking in public places can not be better protected than to always have in his pocket a few of these cups. Not a few public water fountains have a special mechanical device for distributing paraffin cups. This device consists of a long glass tube, which, after being filled with cups, is set into a stell head, which is operated by a small lever. When this lever is pulled the slot is opened and the cup falls out. This machine is usually used for selling cups, a cent being deposited before the lever can be worked.

Another very popular way of distributing water in public places is through the bubble fountain. The fountain operates continuously or is supplied with a faucet for turning the water on. The object of the bubble fountain is, of course, to supply each individual a drink without the necessity of each individual bringing his lips in contact with the same surface. Therefore if the fountain serves its purpose the stream should bubble high enough so that the water can be drunk without the lips coming in contact with the bowl, or fountain.

There are several types of these bubblers. At first they all shot the stream of water in a vertical direction. This was thought to be objectionable, and now a few are made so that the water leaves the bubble at an angle of about forty-five degrees. Some of the fountains are constructed so that the water stagnates inside the fountain around the central portion of the stream of water which rushes out of the bubbler. This is an objectionable feature. In still other styles the fountain is constructed with a bowl which accumulates water and frequently instead of drinking from a stream of water which rises above the fountain and rapidly flows away when it falls, the individual drinks rather from a pool of water which has furnished many other a drink. This, of course, is no better than the common drinking cup. Some of the types which have been constructed to give a flow at an angle from the bubble and thereby satisfy the complaint about the vertical stream have supplied a guard on the side which is far more objectionable than the fault they seek to remedy, the vertical stream. At every attempt to get water from the latter type of bubbler the face rubs against the guard. This, of course, affords a means for the spread of disease by contact.

Attempts to supply small pads of cotton or other matter inside the fountain to act as a filter for the water have been made. This practice is not advisable. It collects bacteria and dirt, and may actually increase the number of bacteria in the water after it passes through the fountain.

The most important consideration in operating bubble fountains is the water pressure. The pressure should be sufficient to force the stream of water at least three inches above the bubbler. The fountains should be of as plain construction as possible. It is my opinion that the small bubblers of the mushroom type are most satisfactory, and that when the proper amount of pressure is supplied the angle at which the stream bubbles up makes little difference.

ARMSTRONG TO VISIT WISCONSIN.

The presence of Dr. Donald B. Armstrong, executive officers of the Framingham Community Health and Tuberculosis Demonstration at Framingham, Mass., and of Michael M. Davis, Jr., Ph. D., director of the Boston Dispensary, among the principal speakers on the program of the postponed annual meeting of the Wisconsin Anti-Tuberculosis Association will make this meeting to be held in Milwaukee Friday and Saturday,

March 21 and 22, one of special interest to the medical men and public health nurses of the state. It will be Wisconsin's first opportunity to hear directly from the celebrated Framingham experiment.

The Friday program will be devoted largely to a discussion of the need for tuberculosis clinics in Wisconsin and it is because of the movement in Wisconsin along this line that the state association has been successful in securing both Dr. Armstrong and Dr. Davis. "A Community Organized Against Tuberculosis" will be Dr. Armstrong's topic and Dr. Davis will discuss the reasons for a clinic. Other speakers of authority will participate in the program, both at the afternoon meeting which will be held at the University Extension building and at the dinner meeting Friday evening at the Milwaukee Athletic Club.

Saturday's meetings, as usual, will be devoted to sectional conferences.

PRACTICAL STUDY OF UNDERNOURISHMENT.

A scientific study into the causes of the alarming prevalence of undernourishment among school children is one of the purposes—in fact the chief purpose—of the Demonstration Nutrition Clinic now being conducted in the Third street public school in the city of Milwaukee under the patronage of the Milwaukee school committee which has charge of administering a fund for special health work in the schools raised by the sale of Red Cross Christmas seals. It is believed that the work in the clinic will direct attention in a very definite way to the relation between undernourishment and remediable physical defects and also to the relation between subnormal weight and the lack of essential food values in the child's diet.

One of the outstanding revelations of the thorough medical examination which has been given every child in the school found to be 10 per cent or more underweight—there were 127 in a school of 664 pupils—except in the very few instances where the parents refused to give their consent, was the large number of pronounced heart murmurs. The majority of these are functional rather than organic and it is a significant fact that the most of these children are from 15 to 20 per cent underweight with rather low hemoglobin.

Fully 80 per cent of the underweight girls and a large number of the boys have goiter and enlarged cervical glands. Three cases of incipient tuberculosis were discovered and in one instance the weighing and measuring of the children has served to uncover a serious case of nephritis. Her attention first arrested by the fact that her boy came home with a report showing him to be considerably underweight for his height, the mother watched him closely. Feeling sure that he was continuing to lose weight, she finally became so anxious that she decided not to wait for his turn at the school clinic. So she took the child to her family physician for the thorough examination which resulted in an order to take the child out of school. The mother brought the report to the clinic with the request that the boy be allowed to come to the school at noon time to eat with the other children as she found it difficult to persuade him to eat the kind of things that she thought he ought to eat.

Clinic finding thus far demonstrate conclusively that poverty is by no means the chief cause of undernourishment among children. The Third street school is an average residence district where a large percentage of the men own their own homes and the women are thrifty housewives. The children are well-dressed, unusually clean and well cared for. Not a single case of pediculosis was discovered in the examinations.

The high average of general living conditions makes especially striking the fact that over 19 per cent of the children in the district are seriously underweight. This situation is believed to be due in a measure to the increased cost of milk products and the tendency of the average family to select milk products as the first place for the exercise of economy rather than the last. The unquestionable lack of fat soluble A vitamins in the food given the children is reflected in the general stunting of growth. The children themselves give subconscious evidence of this fact by the greediness with which they drink milk when it is supplied to them freely. Not a single child among the fifty selected for the feeding demonstration has refused to drink milk and the majority of them drink at least two mug fulls.

Under the direction of an expert dietitian, a well-balanced, nutritious meal selected from foods within the financial means of the average family is served each noon at the school. Nor does the attempt to supply the lacking food elements in the

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child's diet stop here. Through the social service department of the clinic, health instructors go into the home and try to secure such hearty co-operation from the parents that there will be fewer breakfasts of coffee and rolls and more in which a liberal supply of milk and cereals is substituted. Much emphasis is being placed on the avoidance of coffee drinking for growing children and the clinic investigations are showing up in a rather startling way the prevalence of this habit.

The entire demonstration is under the direction of Dr. E. V. Brumbaugh, director of formal public health instruction with the Wisconsin Anti-Tuberculosis Association, and the members of the Association's first class of health instructors is doing the social service work in the homes. Miss Edith Foster, also of the association staff, is supervising this social service work and Miss Elizabeth Baldwin, a member of the health instructors' class and a former home economics' instructor, is the dietitian. Dr. Oscar Lotz, who has charge of the association's department for work among tuberculous soldiers and draft rejects, is the examining physician for the clinic.

A BIT DISTURBING.

Entry of the abbreviation, "Neg." on the record cards of children examined in the Demonstration Nutrition Clinic being conducted in one of the Milwaukee Public schools came near causing a riot among the mothers of the children. These mothers were invited to be present during the examinations in order that they might confer with the examining physician regarding the diagnosis if they desired and it was noticed that a number of them seemed a trifle resentful in their attitude as they watch the filling in of the record cards as the examination proceeded. Finally one of them demanded to know what the doctor meant by calling her child neglected and then investigation proved that many of the mothers and some of the teachers as well had interpreted "Neg." in the same way. There was a general clearing up of the atmosphere when the physician's meaning of the abbreviation was explained.

Economy is going without something you want, in case you should, some day, want something you probably won't want.—*Anthony Hope.*

BOOK REVIEWS

PHYSIOLOGY AND BIOCHEMISTRY IN MODERN MEDICINE. By J. J. R. MacLeod, M. D., Professor of Physiology in the University of Toronto, Canada, formerly professor of Physiology in the Western Reserve University, Cleveland, Ohio. Assisted by Roy G. Pearce, B. A., M. D., Director of the Cardiorespiratory Laboratory of Lakeside Hospital, Cleveland, Ohio, and others. With 233 illustrations, including 11 plates in colors. C. V. Mosby Company, St. Louis. 1918.

The subjects covered by this work, always allotted in the medical curriculum of our colleges to the first period of study, are usually forgotten or the student and practitioner fails to employ his scientific knowledge of the subject to full advantage in the solution of his clinical problems. One cause of this is the lack of correlation between the laboratory and clinical studies, and few of our excellent textbooks in physiology apply the subject to the routine practice of medicine. The work reviewed meets such a want.

It is not intended as a substitute for the regular textbook but is rather supplementary to such volumes, dealing with the present day knowledge of human physiology, insofar as this can be used in a general way to advance the understanding of disease. While it covers the entire subject, emphasis is only placed on such sections as clearly show the value of the application of physiological methods, both of observation and of thought in the study of diseased conditions. It is an excellent practical work on the subject and fills a distinct need.

It is arranged in nine parts as follows: the physiocochemical basis of physiological processes; the circulating fluids; circulation of the blood; respiration, digestion; the excretion of urine; metabolism; the endocrine organs or ductless glands; and the central nervous system.

The feathers of a vulture bound to the feet of a woman in labor, shall surely help her and speed her delivery. (Zimara.)

OUR CREED.

"If I knew you and you knew me, 'tis seldom we would disagree; but, never having clasped your hand, both often fail to understand that each intends to do what's right and treat each other 'honor bright'. How little to complain there'd be if I knew you and you knew me. If I knew you and you knew me, we'd speak of each with courtesy, we'd let no doubting thoughts abide of firm good faith on either side. Confidence to each other give, living ourselves, let others live. Doctor, how pleasant things would be if I knew you and you knew me. You're always welcome down our way, we hope that you will call some day then face to face we each shall see, and I'll know you and you'll know me."—From the Madison County Doctor.

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THERAPEUTIC NOTES

THE TREATMENT OF CONSTIPATION, WITH REMARKS ON THE YEAST TREATMENT OF SOME GASTRO-INTESTINAL DISORDERS.

Chronic constipation is such a common affection, and is seen as a secondary condition in so many derangements of the gastro-intestinal tract, and the general effect on it of medication alone is so unsatisfactory, that a host of remedies have been employed for its relief rather than, let us say, for its cure. Many of the drugs so employed, for instance, belladonna, mercury, and to some extent physostigmine, have other, more important, therapeutic indications which render them objectionable for the relief of constipation over extended periods of time. Then again, in the use of drugs or other ingested agents for the relief of constipation, many of these must be increased in dosage in the individual case to make them effective, an objection that can be obviated to a certain extent by change of drug. Notwithstanding the numerous agents that have been used for its relief, constipation, generally speaking, has remained the bugbear of medical therapeutics. As will appear however, surgery as a routine measure in the treatment of constipation is to be deprecated.

Numerous physical agents, i. e. massage, exercise, proper diet, regular habits, etc., have been recommended for the relief of constipation and with some degree of success in the use of them. A certain number of individuals find the use of these measures somewhat irksome to carry out, or at least inconvenient. At all events, use of them must be frequently supplemented by medicinal agents, which should work as harmlessly and as efficaciously as possible.

Of these agents, cascara sagrada is an old standby; in addition to it, or occasionally as a substitute for it may be used one of the newer laxatives—phenolphthalein, agar (to increase the volume of the feces) and (a medicinal agent used in recent years) liquid petrolatum. Another agent fully as efficacious—if not more so—than those mentioned above is the common household article, compressed yeast.

It is to be remembered in this connection that every case of chronic constipation should be thoroughly studied from the standpoint of the gastro-enterologist and in some cases even of the Roentgenologist—in fact an X-ray picture of the abdomen is extremely important when there is reason to believe that the constipation is dependent on the existence of kinks or bands. As far as this is concerned, we should not forget that in spite of the recent claim of the surgeons that the field of constipation lies well within their province, the vast majority of the total cases of chronic constipation can be satisfactorily treated by the medical man, especially if he avails himself of well-approved physical and medical measures.

It is well to quote in this connection the following words of Sir William Osler (Principles and Practice of Medicine, 1918):

"Captivated by the theories of Metschnikoff, we have been for some years on the crest of a colonic wave, and intestinal toxemia has been held responsible for many of the worst of the ills that flesh is heir to, more particularly arterio-sclerosis and old age. The seniles and preseniles of two continents have been taking sour milk and lacto-bacillary compounds to the great benefit of the manufacturing chemists! But the fad is passing, not, I hope, to be replaced by one even more serious, in which operation is advised for every case of severe intestinal stasis."

The use of compressed yeast in the treatment of chronic constipation has met with marked success in the hands of Hawk and other physicians (see article by them in Jr. A. M. A., Vol. LXIX, No. 15, Oct. 13, 1917, pp. 1243-1247). In fact in ten cases of constipation in which they used yeast, nine were improved or cured. The tenth case was associated with high intestinal stasis and subacute appendicitis, so that this was hardly a fair case in which to expect a curative action of yeast. In one case the movements became so free that it was necessary to discontinue the use of the therapeutic agent. The cases of constipation varied in duration from a few weeks to several years. Fleischmann's Compressed Yeast was the agent employed. One-half to one cake of yeast, was administered about three times a day, usually before meals. In many cases the bowel movements became regular after only a few days of treatment, sometimes immediately.

The use of yeast in the treatment of constipation was by no means new when Hawk and his co-workers undertook their researches on its action. Günzberg (Münchener med. Wochenschrift, July 7, 1896, pp. 631-632), recommended small doses of bankers' yeast in the treatment of enteroptosis, stating that one of its good effects was that it enabled the victims of the disease to take on the necessary fat. Aaron (Diseases of the Digestive Organs, etc., 1st edition 1915, 2nd edition 1918) in his chapter on constipation, writes thus about the treatment of atonic constipation: "Good results are reported from yeast taken once or twice a day, according to the number of bowel movements caused."

The full action of yeast on the gastro-intestinal tract is well worth determining. According to Hawk and his co-workers, there is associated with all actions of yeast a general improvement of the patient's general condition. With this accords the statement of Günzburg mentioned above that the patient takes on fat. It is possible that the general increase in well-being may be associated with an increase in general tone, which in turn may affect peristalsis favorably, and bring about a daily evacuation, as a permanent condition. It is noteworthy in this conection that the chief use of yeast has been in connection with cases of atonic constipation. It, however, does not seem to be contraindicated in the spastic constipation of enteroptosis (see reference to Günzburg above), which according to Günzburg needs oil enemata for its relief.

Yeast has been successfully used in various gastro-intestinal conditions, including typhoid fever, and the gastro-intestinal symptoms of influenza. The work of Hawk already mentioned includes that done on 3 cases of gastro-intestinal catarrh, in which these were treated with yeast with good results. Favorable reports on the use of yeast in gastro-enteritis have long been known, the substance affecting especially favorably the gastro-enteretis of children (see article by Thiercelin and Chevrey, Revue de Therap. Medico—Chirugicale, 1899, pp. 797-803), to whom it may be given per rectum. On account of its vitamine content, yeast promises to be of importance in infant-feeding.

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ORIGINAL ARTICLES

DIGITALIS IN CARDIO-RENAL DISTURBANCES.*

BY O. M. LAYTON, M. D.,

FOND DU LAC.

To William Withering, an English physician and botanist, must be given the credit for introducing digitalis into our Materia Medica, after its having been used as a household remedy in England for years. It received its first official recognition in the Edinburgh Pharmacopeia, issued in 1783, as a remedy for dropsy, which was then considered a primary condition. It was regarded as a diuretic, any cardiac effect noted being considered secondary.

Withering, in 1783, published a book entitled: "An account of the Fox Glove and some of its Medical Uses; With Practical Remarks on Dropsy and other Diseases." In his preface he says: "Digitalis was admitted to the Pharmacopia, from which it will soon be dismissed if the present random use of it and the dosage that is customary in London shall continue."

Since Withering's time to the present digitalis has been more or less indiscriminately prescribed for patients with all sorts of cardiac lesions, and not always to the benefit of the patient. There can be little excuse for its random use today. With the mass of experimental and laboratory data and accurate clinical observations available we may consider its pharmocology pretty definitely settled.

The action of digitalis is myogenic, that is, it acts directly upon the bundle of His and the heart muscle. The heart under the influence of digitalis exercises a stronger and more prolonger systolic pressure with greater diastolic relaxation. There is no immediate gain in muscle power, but with a lessened number of beats per minute the heart accomplishes more work with less effort. With lessened conductivity and diminished irritability, and re-establishment of normal rhythm, there is gain in cardiac nutrition, and the entire cardio-vascular system is improved.

Digitalis probably has no direct effect upon the blood vessels, and the arterial pressure may be raised according to the type of circulatory disturbance and the compensatory factors present in the given case. No change occurs in the tension of the pulmonary circuit owing to the greater dilatability of these vessels, neither is there any marked change of pressure in the venous circulation.[1]

There has been much discussion as to how digitalis acts as a diuretic, whether by direct action upon the renal epithelium and vascular tissue, or whether diuresis is the result of the cardio-vascular improvement. The weight of opinion seems to be that the latter is true. I am convinced, as the result of my own clinical observation, that the diuresis is a secondary effect.

Cumulation in the case of digitalis is the result of a simple summation of amounts absorbed and fixed in the tissues, probably of the heart, and, owing to the firmness of this fixation the intake in continued administration of the drug is in excess of the elimination.[2] Nausea and vomiting is a further expression of toxic action by direct irritation of the vomiting center in the medulla, and is frequently preceded by sudden loss of appetite, and coupled beats.[3] Since a therapeutic and not a toxic effect is sought the drug must either be discontinued or the dosage reduced. Without any question the tincture is the preparation of choice, since it is reliable and reasonably permanent. There are times when the infusion seems to be desirable, apparently producing less gastric disturbances than other preparations, possibly due to its mode of preparation. It is quite reliable, retaining its activity for a month or more.[4]

The solid preparations should be reserved for the cases that object to liquids, and when convenient for prolonged administration. While usually given by the mouth, there are times when absorption is so slow on account of the gastro-intestinal

*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, October 2, 1918.

irritation, or the condition of the patient so urgent, that the intramuscular and intravenous routes are the ones of choice. I have seen prompt digitalis effects follow the administration of small doses, I mil intramuscularly, when the prolonged administration of large doses by the mouth had utterly failed. But in these cases, especially where the drug had been given orally, we must be cautious in our dosage by these routes, beginning with not more than one-fourth to one-half the dose decided upon, and repeating the dose as indicated. In the matter of dosage I am convinced that the single dose of digitalis tincture of one to four mils daily to be the best method. As soon as the desired effect is secured, or toxic symptoms appear, reduce the dosage to the amount necessary to maintain the effect.

Strophanthus and its preparations are too unreliable when given orally to place my dependence upon them.[5] But strophanthin and ouabain are very reliable and satisfactory when given intramuscularly or intravenously. The initial dose should not exceed one-half mg., and be repeated in twelve to forty-eight hours as indicated.

In the presence of edema and gastric irritation, especially if the case is urgent, we should depend upon the hypodermic needle until conditions improve.

When shall we give digitalis? The clinical picture of the cardio-renal patient is familiar, into a discussion of which I need not enter. There is just one thing to determine from the viewpoint of this paper, and that is the question of cardiac insufficiency, since we assume that is the only condition in which digitalis is indicated, and it is interesting to record here that Withering, while giving digitalis as a diuretic, observed that he secured the best results in the cases which, according to his description, we recognize as having been cases of cardiac insufficiency.

The diagnosis of a well-developed case of cardio-renal insufficiency is easy; the diagnosis of an impending insufficiency with a clear indication for the administration of digitalis as a prophylactic measure, is not always as easy. A correct interpretation of the findings made with the common blood-pressure instruments is of the greatest value in this connection. I believe that we should adopt a routine technic in the use of this instrument, and always supplement the auscultatory method with the digital, and pay more attention to a study of the heart sounds and less attention to the needle of the instrument. We can all profit by Sir James McKinzie's statement that the possession of a blood-pressure instrument does not make a heart specialist of its owner.

I wish to refer briefly to a few of the conditions in which digitalis is so frequently indicated, but in which a degree of caution should be exercised in its administration.

Most of our cardio-renal cases have arrived at or are past middle life, and we are dealing with damaged tissue in the cardio-vascular-renal system, and occasionally mechanical disturbance within that circuit, such as impaired heart valves and portal congestion.

Digitalis will not replace old tissue with new, and if we attempt to make the heart overcome mechanical obstruction by drug stimulation we may do more harm than good. This is particularly true where we are dealing with leaky stenosed valves.

If the heart is failing, a careful estimate should be made as to whether it is the result of the mechanical difficulty or myocardial degeneration. If mechanical, digitalis will be of great benefit; if due to muscle degeneration rest and other measures should overshadow the use of digitalis.

It is well known that in auricular fibrillation digitalis frequently produces brilliant results, and again fails. We now recognize that the result depends upon whether the origin of the disturbance is myogenic or vagal. The cases with the cardiac factor are the ones benefited by digitalis. Auricular fibrillation is more common than supposed, as we will find by routine comparison of the apex and radial beats.

SUMMARY.

It may be taken for granted that if an active preparation of digitalis is administered in proper dosage by appropriate method without securing results, that you have made a mistake in your diagnosis.

Digitalis is one of the most valuable drugs in the Materia Medica, frequently achieving results comparable with skillful surgical intervention, but if unwisely used the results may be as disastrous as those following bungling surgery.

The indications and contraindications are quite clear if we understand its use and have made a careful diagnosis of the cardiac condition of the

patient before us. If cardiac insufficiency exists or is impending, digitalis is indicated.

The cardio-renal patient should not be sent out of the office with a prescription for digitalis. If he needs digitalis he has about used up his cardiac reserve, and digitalis is a first mortgage on his heart; if he is permitted to go about without first making every possible effort to replenish his reserve you have attached a second mortgage without any precaution for meeting the first. Confine him to his bed or home until he is able to make a new start. Do not expect the impossible of digitalis.

Digitalis has been given in too small doses. If the patient is in bed there is no danger in large doses given to physiological effect, whenever necessary.[6] Age and sex require but little variation in size of dose.

Selection of the preparation and method of administration and dosage must be carefully determined for each individual case. There is no essention difference in the effect produced by the different preparations of digitalis and strophanthus when given by the proper method, and in sufficient dosage.[7]

I think the intramuscular and intravenous routes should be oftener used in the cardio-renal conditions, because these patients so often have not only a gastro-intestinal tract which renders absorption and time effect of the drug uncertain, but they frequently demand immediate results which can only be obtained by these routes, but the oral administration may be used as soon as conditions warrant it.

In the presence of edema, digitalis can be expected to influence the edema only to the extent of its beneficial effect upon the heart. The chemical factors involved, such as sodium chloride, retention, toxemia and renal insufficiency must be dealt with independently.

The degree of hypertension present in no way contraindicates the use of digitalis if indicated. We may consider the hypertension a compensatory process to be maintained temporarily, at least. If the heart needs digitalis we may safely disregard the existing hypertension.

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DISCUSSION.

Dr. A. J. Hodgson, Waukesha, Wis.: I wish to compliment Dr. Layton on the great care shown in the preparation of this splendid paper. The Society may be well pleased to have it presented. Practically all of the points taken may be accepted. There are a few minor points that might be more fully discussed.

I fully believe that the diuretic effect is secondary as the doctor has stated. The kidneys cannot act upon blood which does not reach them. The increased circulation through them gives them more blood to act upon, hence greater excretive power.

We use very little tincture in the "Spa". We do not seem to get as good an affect as from the infusion or some dried standardized products, one of which is digipuratum. The infusion is serviceable when made from standardized and tested leaves, but of course will not long retain its activity. The dried product, called digipuratum is in tablet form, each tablet equal to one and one-half grains of digitalis leaves. This tablet we find too large a dose, as at times, within half an hour after giving this dose, we have had patients complain of a "gripping of the heart," and have found their pulse rate to have been lowered very much, and in order to prevent this we give ¼ tablet, and repeat often enough to give the desired therapeutic effect.

The therapeutic indication for digitalis is well brought out by the paper. Cardiac insufficiency due to lack of contractile power and tone, is the indication for use of digitalis in cardio-renal disease, and how much, should be indicated either by the relief of the patient's symptoms or by beginning toxic effects of the drug.

I should put what Dr. Layton says in regard to mechanical obstruction in a slightly different manner. When the heart is failing, it is well to know that there is enough active muscle tissue to do the work if it is stimulated. If there is that much muscle, then use digitalis.

Digitalis, in cardio-renal disease, is not to be used to raise blood pressure, nor as a diuretic, but, it is to be used in failure of the heart before myocardial degeneration has taken place.

Dr. H. P. Greeley, Madison: In regard to the discussion about the preparation to be used, I believe that the tinctures are not as successful for the general practitioner, mainly because they have stood on the drug-

gists' shelves for so long a time. A fresh tincture is as good a preparation as you can get, but a sold tincture deteriorates, of course, in just the same way that the infusion deteriorates.

Dr. Layton spoke about using strophanthin and ouabain intravenously or subcutaneously in heart failure. The caution should always be given that these drugs cannot be used directly after digitalis without running the risk of bringing on acute failure of the heart. You must allow sufficient time to elapse between the digitalis and strophanthin so that all the digitalis is out of the body. A great many of the fatal results that have been reported are due to the immediate use of strophanthin after the administration of digitalis. If strophanthin is to be used I feel very strongly that it ought to be given intravenously, because it is exceedingly irritating when given intramuscularly.

Dr. A. E. Bachhuber, Mayville: I wish to offer a word about the use of the fresh infusion prepared by putting the desired dose,—say two grains of a reliable preparation of the powdered leaf into a dry cup and filling the cup with boiling hot water—about two-thirds full.

Let it stand long enough to cool and then take the entire contents of the cup.

I have used this quite extensively, with good results—it is very reliable and well borne.

Dr. O. M. Layton, Fond du Lac: Mr. Chairman and Gentlemen: The therapeutics of Digitalis is a large subject, and of course it is impossible to cover all of the points in a brief paper. There is a general feeling that a long paper on therapeutics is going to be tiresome; so when a doctor writes such a paper, he tries to make it short.

Two points I am glad to see brought out, however, one with regard to the preparations. If all of us have not read the classic work done by Eggleston and Hatcher, we will do well to read their articles along these lines. The digitalis preparations are reliable for a year or more. What we should all do is what I am doing at the present time in my town, and that is, insist that my druggist shall buy his digitalis in ounce containers, with the date of preparation marked upon them, and that he should buy them often enough so that there is no posibility of deterioration. Your druggist can supply you with a fresh supply, or obtain a fresh supply annually, so there is no excuse for using old preparations. I have used infusion and think it is very reliable. Infusions properly made up and kept under proper conditions, will retain their activity for several months. So we can safely figure that they are good for a month or more.

I am very glad to have the question of the previous administration of digitalis brought out, because it is a very important point. You can have a funeral very easily by the intravenous use of digitalis preparations if you do not consider that point very carefully. It is taken for granted always that before an intramuscular or intravenous injection is given, that it has been determined whether the patient has previously received digitalis or not.

I think that Dr. Hodgson's point in regard to the question of an old myocardio case with stenosed valves is a good one. Those cases call for a good deal of judgment in the administration of digitalis. Of course we have to determine whether the heart muscle have sufficient power to justify the administration of digitalis, to produce a slower contraction and permit of better filling of those valves. If we are not certain as to those points, we had better put the patient to bed and leave digitalis alone, and he will perhaps live longer without it than he will with it.

THE ADEQUATE TREATMENT OF SYPHILIS.*

BY J. J. SEELMAN, M. D.,

MILWAUKEE.

During the past few years my work has brought many cases of syphilis under my observation. I have had opportunities to observe the methods employed by different physicians in the treatment of this disease, and to note the results obtained by those methods. The drugs used, of course are few. Mercury, arsphenamine, iodides and the cacodylates probably cover the list. But in regard to the selection of the drug or combination of drugs to be employed, the dosage, the method and frequency of application and the hygienic control of the patient there seems considerable diversity of opinion among physicians.

I have had two convictions forced upon me in regard to syphilis. The one that the quite formidable prevalence of active cases of the disease is not recognized by the average physician, and he is not sufficiently on his guard to detect signs of its existence. The other that the disease is not, as a rule, adequately treated when it has been recognized.

The first conviction is based on the fact that it is rather a common experience in our laboratory to obtain definitely positive reactions on persons who have made the rounds of numerous physicians, none of whom suspected the disease, and who were referred for Wassermann tests only after they came under the scrutiny of the consultant or specialist.

The second conviction is based on a comparison of the usual methods adopted in the treatment of

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*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, October 2, 1918.

the disease, with the methods that should be adopted in the light of our more recent knowledge of the subject.

Clinical and serological surveys made by investigators indicate that between ten and twenty per cent of the population of this country is infected with syphilis. The percentage findings vary, of course, with different classes of people and with different methods of diagnosis.

The actual incidence of syphilis is probably much higher than indicated by these surveys, as the Wassermann test is not always positive in latent and hereditary syphilis, and many persons infected with treponema pallida do not show any clinical signs of that fact. Of special interest in this connection is the work of Warthin. He came to the conclusion that in order to obtain dependable information as to the prevalence of syphilis it is not enough to make Wassermann tests, take histories and examine patients, nor even to look for gross evidences on the post mortem table. He showed that the ordinarily accepted post mortem criteria of the presence or absence of syphilis are extremely inadequate, and that very often a thorough, painstaking microscopic search of tissues and organs will reveal spirochetes or evidences of their presence in individuals who show no gross syphilitic lesions, and who during life presented none of the ordinarily recognized symptoms of the disease. In 750 autopsies made at Ann Arbor he found evidence of syphilis in 40 per cent of the material. His work is open to some criticism, because he cannot show conclusively that the lesions he regards as syphilitic are really due to treponema pallida infection, nor even that the spirochetes he has been able to find in many of these lesions are true treponema pallida. However, even allowing for a considerable margin of error, one cannot help but feel that his method of supplementing gross post mortem findings with a careful and exhaustive microscopical search of the tissues and organs for spirochetes and their lesions marks a distinct epoch in the study of syphilis, and if followed by others will show that syphilis is far more prevalent than was suspected even by the most pessimistic.

Because of the war the already appalling prevalence of syphilis will be further increased. Hazen, quoting French authorities states that in 1916 there were over 200,000 cases of syphilis along the French battle line alone, and that in Paris the disease has increased 66.6%. He also states that he has been told by unimpeachable authorities that syphilis has greatly increased in the Italian army and among the wives of the soldiers. Hecht estimates that since the beginning of the war an equivalent of 60 divisions have been temporarily withdrawn on account of venereal disease. At the time his article was written he estimates that the Austrian army contained several hundred thousand syphilitics.

In our own army every effort is being made to reduce to a minimum the venereal menace. Judging from statistics thus far reported the measures that have been instituted for this purpose have been reasonably successful. However, all systems of control which army men have devised have a leak, which it has thus far been impossible to stop, namely, the furlough. Virile men on their leaves of absence tend to excessively indulge, and consequently excessively expose themselves in an effort to make the most of their brief respite from enforced continence. This leak is the more treacherous when the men reach countries in which the syphilization of the civilian population, higher even in normal times than in this country, has been greatly augmented on account of war conditions.

It is also highly probable that many cases of latent syphilis among the soldiers will become active because of lessened resistance due to exposures and injuries.

It is, therefore, highly important for the future welfare not only of the returning soldier, but also of the civilian population, that every general practitioner acquaint himself with all the available methods of diagnosing the disease, and that he be constantly on the lookout for it. Possibly one out of every three or four patients that enters the consulting room is a spirochete carrier, and one out of every ten an active syphilitic. After the war this proportion will doubtless be considerably increased.

Next to the need of recognizing the disease comes the need of proper treatment when it has been recognized. While this paper is to concern itself chiefly with methods of treatment, I am going to consider briefly some of the newer conceptions of the epidemiology, pathology and symptomatology of syphilis, especially insofar as they may influence our therapeutic attitude.

Syphilis is not as essentially a sex disease as

has been supposed. Congenital and extragenital infection is probably much more frequent than present available statistics would indicate. We know now that the typical hunterian chancre in sexually transmitted infection is the exception rather than the rule. Unless an extragenital chancre is typical in appearance it is usually not recognized. Even typical chancres are often overlooked. I have the records of a number of patients who presented themselves for darkfield examinations after having carried a typical chancre for weeks, during which time they consulted a number of different physicians none of whom suspected the true nature of the lesion. It is reasonable to assume that the extragenital chancre is non-typical in at least the same proportion of cases as it is in genital infections. Taking into consideration this type of lesion which is probably never recognized, and the typical chancres which are overlooked, the conclusion is justified that extragenital infections are considerably more frequent than published reports would indicate. Noguchi states that under favorable conditions treponema pallida remain viable for about twenty-four hours after separation from a lesion. Uhlenhuth and Mulzer find the viable period to be twenty-four hours. Evidence also seems to point to the existence of a granule stage in which form the organism may be spread intermediately and from which mature spirochetes may develop. When, with these facts in mind, one considers the large number of syphilitics with open primary and secondary lesions who are permitted to freely mingle among their families, their friends and the general public, and even to hold positions which render them doubly dangerous, such as waiters, cooks, bar-tenders, barbers, etc., one understands better the need of being on the lookout for syphilis even in cases which give absolutely no history of a venereal infection.

I venture to say that nine out of every ten physicians associate with a recent syphilitic infection an invariable symptomological sequence, viz., the typical, indurated hunterian chancre appearing from two to four weeks after exposure, followed in six weeks to two months by the classical secondary lesions. Just why it should be expected that a syphilitic infection will always be followed by a definite and invariable symptom complex does not appear. We do not find, nor expect it in any other infectious disease. As a matter of fact, just as the atypical chancre is more frequent than the typical, so mild, evanescent secondaries are more frequent than the florid type, and complete absence of demonstrable secondaries are probably not infrequent.

The character of response to a syphilitic infection is determined by two principal factors: (a) the strain of infecting organisms; (b) the degree of immunity of the host. Noguchi has shown that various strains of spirochetes with varying morphology produce constant varying types of lesions. Reasoner has also demonstrated the selective affinity of certain strains of spirochetes for certain tissues. It is, therefore, highly probable that differences in localization and symptoms, and differences in aggressiveness and consequently in the severity of the lesions produced are due at least in part to differences in strains of the invading organisms.

In part, also, such differences are dependent on immunity factors. It is easily conceivable that some persons may have so adequate an immunity mechanism that spirochete pallida find it impossible to invade their tissues. From this extreme to the other, an entire absence of defensive forces, there is, doubtless, a coincident variation in tissue pathology and consequently in symptomatology, from a mild, scarcely recognizable symptom complex to the fulminating type of the disease.

As a matter of fact the human race has developed a very high degree of immunity to syphilis. In the majority of cases, when an invasion does take place, the individual assumes the role of spirochete carrier, and so long as the immunity mechanism remains intact the organisms are unable to bring about any serious disturbance. It should be remembered, however, that immunity to any disease is only relative, and that an adequate immunity may be rendered inadequate or even be entirely destroyed, by unhygienic living, especially dissipation, intercurrent diseases, or the natural changes that come on with age. I believe the last factor is especially operative in syphilis, and is the reason why so many cases remain latent during the virile period of the patient's life, only to become active again with the oncoming of the lessening resistance of age. There is still much obscurity concerning the immunity mechanism in syphilis. For instance, it is generally supposed that the Wassermann reaction is brought about by antibodies in the blood. The fact is, however, that the Wassermann test is not a specific reaction, and that the substances in the blood which bring it

about are probably nothing more than coincident by-products of the disease. Noguchi has shown that "a syphilitic animal may give a positive complement fixation with various lipoids without at the same time containing any antibodies for the treponema pallida." He finds this also true of human sera except in certain late tertiary cases, in which the reaction may be specific. Kolmer and Broadwell, Jr., found that there is no relationship in vitro between complement fixing bodies in syphilitic sera and its immune properties. They believe the lytic type of immunity to be either entirely absent or at least of minor importance in syphilis. While agglutinins have been demonstrated in the blood of experimentally immunized animals it has not yet been shown that they are a factor in immunization in human syphilis. In just how far an increased knowledge of the immunity mechanism operative in syphilis will aid us in the treatment and control of this disease is, of course, problematical. It surely offers a hopeful field for investigation for there is, I believe, no disease in which natural immunity factors are so vitally concerned and so effective as in syphilis.

The epoch making work of Warthin will force us to re-write the pathology of syphilis. The typical lesion of syphilis is not localized and circumscribed but generalized and diffuse. Not aggressive and destructive but mild and slowly productive. In by far the larger proportion of cases no gross anatomical lesions are presented, the disease being demonstrable only after a more or less careful microscopical search. The lesions begin as lymphocytic and plasma cell infiltrations, and gradually undergo fibrosis. Warthin has found them in the "myo-, endo-, and pericardium, the aorta, pulmonary and other large arteries, nervous system, liver, pancreas, adrenals, testis, prostate, pre-vertebral and mesenteric tissues." He finds them in various stages of development, from those just beginning, to dense masses of fibrous tissue. In the latter he never found spirochetes, and they can, therefore, be considered as healed areas. However, he has never seen a case in which there were no active lesions present somewhere in the body. As already stated, he found lesions characteristic of syphilis in nearly forty per cent of all his autopsy cases. In a large number of these the Wassermann was negative and there were no definite symptoms of syphilis during life. In one series of 165 syphilitics he could demonstrate the treponema pallida in fifty, in all of which there had been a negative Wassermann and no evidences of syphilis during life.

Having in mind these newer conceptions regarding some of the phases of syphilis, one approaches the question of the methods of treating the disease with the thought that these perhaps, too, need more or less revision. What constitutes adequate treatment in syphilis? There are few questions that are given a more diversified answer by authorities. From the most intensive methods to an almost total neglect of the patient, one can find authority for almost any kind and degree of treatment. If our newer knowledge of syphilis teaches us any one thing more than another, it is the fallacy of adopting any stereotyped mode of treatment, and the need, long taught by some authorities, of treating each patient in accordance with his individual requirements, as evidenced by his particular idiosyncracies, pathology and symptomatology. It is not a question of choosing an intensive method, or a passive attitude, or compromising between the two, but a question of adequate treatment. What is entirely adequate treatment in one case may be entirely inadequate or even distinctly harmful in another. The practice of adopting and recommending a stereotyped form of treatment without any effort at a classification of cases must inevitably lead to much mischief.

I offer herewith tentatively a classification of syphilitics for purposes of treatment, and the therapeutic indications for each class. It is not my intention to consider the minuter details of treatment, but only the general principles that should guide us in handling the different classes.

Class 1. Cases diagnosed in the early primary stage. At this stage if seen early enough, it is possible that the disease is still localized, or at most has spread only to the neighboring lymph glands. If a generalized diffusion of the spirochetes has taken place, they are still lodged in the perivascular lymph spaces, with perhaps only a beginning mild inflammatory reaction, and are readily accessible through the blood stream. They have had no opportunity to acclimate or entrench themselves. Under these conditions much can be expected from a proper course of treatment. This should be intense and vigorous. Many recommend at least eight intravenous injections of arsphenamine given each a week apart, together with intramuscular injections of mercury. This method has

been condemned by some, who point to the fact that the intervals between injections permit spirochetes to become arsenic fast. Akatso and Noguchi have shown that by exposing succeeding generations of spirochetes to increasing amounts of arsenic in vitro a very highly tolerant strain can be developed. It is very probable that a similar tolerance develops in vivo, and that this is the reason for the failures of intensive arsphenamine treatments. The tendency now is, and it is, doubtless, a tendency in the right direction to give, where intensive treatment is indicated, a large dose of arsphenamine daily or every two days until three, four or even five doses are given, followed by a rest period of two or three weeks, and then by a vigorous course of mercury. This procedure may be repeated two or three or even more times (depending on the Wassermann and spinal fluid findings) at intervals of several months. The underlying idea of this method is to more nearly approach Ehrlich's original conception of a "therapia magna sterilisans," and to prevent the development of arsenic and mercury fast organisms.

Class 2. Cases diagnosed in the late primary and secondary stages. In these cases a generalized distribution of spirochetes has taken place, but they are still quite accessible. The inflammatory reaction is in the stage of hyperemia, with round cell infiltration, and spirocheticidal substances introduced into the blood can reach the organisms much more readily now than they can later if the latter are given an opportunity to entrench themselves in dense bundles of connective tissue.

The intensive treatment recommended for the early primary cases is also indicated in this class, but a larger number of courses are necessary to entirely sterilize the system.

I don't think we can sufficiently emphasize the need of intensive and sustained treatment in the early stages of syphilis, for it is then and then only, that a cure can be effected. To follow the practice of Heidingsfeld and give only a single injection of arsphenamine, is a great injustice to the patient. True, many of the cases so treated will go on to a negative Wassermann. But so also will cases that receive no treatment at all. They become Wassermann negative, spirochete carriers, undergoing slowly productive visceral changes, and are always potential active syphilitics, tabetics and paretics.

Of course, it goes without saying that whenever the intensive treatment of syphilis is decided upon, the physical condition of the patient must be carefully watched, and the intensity of the treatment gauged according to his endurance.

Class 3. Tertiary cases with active syphilitic lesions and negative spinal fluid. In these cases the aim should be first of all to arrest and if possible heal the presenting lesions. The mode of procedure must depend largely on the individual case. If the physical condition is generally good, especially if the heart and kidney seem reasonably normal, an intensive course may be decided upon. Usually such lesions are of an active, inflammatory or gummatous character, and will respond quite readily to treatment. In favorable cases several courses of intensive treatment may lead to a negative Wassermann. I believe, however, that in these cases the securing of a negative Wassermann should not be a prime object. Very often it can not be obtained with any amount of treatment. They all have, in addition to the active and destructive lesions, the fibrous productive lesions with buried spirochetes practically inaccessible to treatment. Any attempt to institute treatment sufficiently vigorous to reach and destroy these deeply entrenched spirochetes, would necessarily need be so intense that the injury done to normal tissues would far more than counterbalance the good that could be attained. After the active lesions have been healed, they should be handled in much the same manner as the following group.

Class 4. This constitutes a large group of cases with vague, indefinite symptoms, often rheumatic or neuritic in character, sometimes referable to the cardiovascular or renal systems, sometimes to the stomach, bowels and reproductive organs, less often to the respiratory system. It also includes neurotic cases without definitely demonstrable central lesions and negative spinal fluid. In all such cases a Wassermann test should be made. It will rarely be found strongly positive, more often mildly positive or negative. It is here that, I believe, we should revise our interpretation of mildly positive Wassermann reactions. I believe that in all these cases, whether the test is strongly or mildly positive, anti-syphilitic treatment should be instituted. This should not be an intensive form of treatment. Even the most intensive treatment will not eradicate the disease, and will usually do more harm than good. It cannot reach the entrenched organisms, and may injure the non-invaded tissues to

such an extent that they become more vulnerable. The object should be to give just enough treatment to destroy the more readily accessible organisms, and to continue treatment sufficiently to prevent involvement of the non-invaded tissues. This can be accomplished by giving one or two injections of arsphenamine and at least three courses of mercury during the year. The courses of mercury should be repeated every year. Schamberg, et al, have shown that the calomel ointment is just as effective as the blue ointment. A properly prepared calomel ointment is as clean and as easily rubbed in as so much cold cream, and patients submit to this form of treatment much more readily than to the old-fashioned, dirty blue ointment. They can usually be induced to take several courses of twenty-five or thirty rubs each year which will prevent, not only an involvement of the still healthy tissues, but also a progression of the infected areas. Potassium iodide should also be administered a few weeks during each interval of mercury treatment.

I realize that there will be considerable objection on the part of many practitioners to consider cases coming under this group, especially when the Wassermann test is only mildly positive, as being syphilitic. I myself do not believe that they should be definitely so classified and told that they are syphilitic. Such knowledge will often bring about a mental state that will do far more harm than the disease itself. However, they are entitled to the benefit of the treatment, not only for the purpose of making them more comfortable, but also to prevent progression of the disease. They can be told that they have some blood discrasia that will require repeated purifying to prevent serious consequences. The purifying of blood is a process that seems to appeal to most of the laity, and to which they readily submit. Of course they must be carefully watched, and if it is found that the mercury does not agree with them, or that their symptoms do not subside, that fact may be considered as a therapeutic negative test, and treatment discontinued. On the other hand if, in those cases in which the treatment controls the symptoms, the above outlined plan is carried out, I am sure that the future incidence of cardio-renal cases, aneurisms, arterio-scleroses, cerebro-spinal syphilis, tabes and paresis, will be greatly reduced.

Class 5. Not infrequently persons who are perfectly healthy, and who present no objective abnormalities, but with a history of a past syphilitic infection, are found to be Wassermann positive. What shall we do with them? Here again I believe it to be a serious blunder to institute intensive treatment in an effort to negative the Wassermann reaction. It is in these cases that Heidingsfeld's advice to "let sleeping dogs lie" is justified. The immunity mechanism of the system is adequately controlling the disease, and the spirocheses are probably doing little more harm than the streptococci in the mouth or colon bacilli in the intestinal tract. A lumbar puncture should be made, and if the spinal fluid findings are negative, the policy of watchful waiting is indicated. At the first appearance of objectives, the patient should be treated according to the plan outlined for class 4. If the spinal fluid is positive, however, the treatment outlined for the following group should be instituted.

Class 6. In every case of syphilis or suspected syphilis an examination of the spinal fluid should be made. It will be found that not infrequently cases diagnosed in the primary or secondary stage, even after intensive treatment, will still show a positive fluid after the blood has become negative. A continuation of the intensive treatment will, as a rule, clear up the fluid. On the other hand, if no fluid examination is made, and the patient pronounced cured on the evidence of the blood findings alone, and if a nervous involvement is present, he will inevitably, sooner or later, reach a stage in which effective treatment becomes extremely difficult or even impossible. A nervous involvement of syphilis is revealed in the fluid long before any objectives are presented, and long before any destructive changes have taken place. We have, therefore, in spinal fluid examinations, a means of recognizing at its inception an involvement that will ultimately, if left to itself, lead to the most pitiful of human ills. And when it is understood that at this early stage this involvement is still amenable to treatment, that the majority of these cases can, if properly treated, be cured, and that consequently, the number of future tabetics, cerebro-spinal syphilitics and paretics can be greatly reduced, the importance, both from an economic and humanitarian standpoint, of making routine spinal fluid examinations must become evident. It is hardly within the scope of this paper to go into the details of the treatment of cerebro-spinal syphilis. All I wish to do here is to point out the

need first of an early diagnosis, and second of intensive treatment continued until the fluid has been cleared up. Even when the diagnosis is made later, after destruction has begun, this intensive treatment is indicated. One is justified here in risking the possible injury that the treatment itself may inflict, because it is the lesser of two evils.

In a general way it may be said that the treatment should consist of weekly intravenous arsphenamine injections, mercurial injections or inunctions, and the administration of iodides. If the spinal fluid does not clear up even after prolonged and insistent treatment, one is justified in resorting to intraspinous treatment. Despite the pessimistic views expressed by Sachs, later controverted by Fordyce, the majority of recent investigators are agreed that intraspinous treatments offer the best hope for an amelioration and even cure of the disease in those cases in which the intravenous route has proven unsuccessful. In cerebro-spinal syphilis more than in any other form of the disease, the individual requirements call for a nicety of therapeutic adjustment that can be done full justice to only by one who has given the subject special study. Wherever possible, these cases should be turned over to the care of the specialist.

In all cases of syphilis, the general hygienic care of the case is as important as direct therapeutic measures. I can think of no better way of emphasizing this point than by quoting Warthin.

"The syphilitic is pathologically 'damaged goods'; and the damage is a progressive one. He wears out sooner, his viscera more quickly reach their histogenetic limits, he actually becomes prematurely old, and there is a constant strain upon his defensive powers. All of these are arguments for the prevention of syphilitic infection rather than for its cure. No man can acquire syphilis, become clinically cured, which as far as we know means latency of the infection, that is, spirochete carrying, and have the same potential body-value and expectancy of life as before the infection.

"This pathologic conception of the syphilitic, as probably always a spirochete carrier once the infection is acquired, should influence the therapeutic management of this chronic infection. The syphilitic, even when apparently perfectly well, should have his life laid out for him along lines tending to prevent the reawakening of the virulence of the organism or an increased susceptibility of the body tissues and organs. This is done for the patient who has once had clinical tuberculosis; when properly treated his future life is planned to prevent the reawakening of his infection, because he, too, is usually, if not always, still a carrier of the infective agent. But in the case of the syphilitic such hygienic measures are not applied, implicit reliance is usually placed upon a certain amount of salvarsan or mercurial treatment, while the infected individual is permitted to take up his life again as if he were an ordinary individual, and, as a rule, he succumbs prematurely to the stress and strains incident even to ordinary living. The treatment of syphilis, as it is ordinarily carried out, looks only to the present moment; it should look to the whole future life of the infected individual."

SUMMARY.

Syphilis is a far more prevalent disease than is usually supposed.

There will be a considerable increment of cases of active syphilis after the war.

Because of the well developed relative immunity of the human race to syphilis, the majority of infected persons become mere spirochete carriers, with Wassermann negative blood, and never develop any symptoms which are definitely referable to the disease. In these cases there is usually no history of well defined primary or secondary lesions, because immunity factors prevent their occurrence.

In only a small proportion of persons who become infected, immunity resistance is on a sufficiently low level to admit the development of definite primary or secondary lesions.

Whenever recognized in the primary or secondary stage, the patient should, whenever possible, receive intensive and sustained treatment.

For intensive treatment daily or bi-daily, intravenous arsphenamine injections are preferable to the weekly injections, provided, of course, that they can be tolerated.

In tertiary cases the intensive treatment is only exceptionally indicated. In many cases it may prove harmful. These cases should all be treated according to individual requirements.

In every case of syphilis a lumbar puncture should be made. In primary and secondary cases this should be done after treatment has been completed and before the patient is discharged as

cured, and in tertiary cases as soon as the disease has been diagnosed or is suspected of being present. If the findings are positive the patient should at once be turned over to the specialist.

DISCUSSION.

Dr. J. C. Sargent, Milwaukee: This paper of Dr. Seelman has been a most interesting presentation of a very timely subject. May I add emphasis to one point which he brought out, and that is the necessity of very intensive and prolonged treatment in all cases of primary and secondary syphilis. Certainly if anything can be accomplished in the treatment of syhilis, it can be done in the first two classes.

Were I to differ with Dr. Seelman in any respect, it would be only in going further in the treatment of the so-called latent syphilitics; those presenting nothing but a history of syphilis and a positive Wassermann. I do not believe in the advisability of "letting a sleeping dog lie". It seems to me the most prudent time to kill the dog is while it is asleep. If we allow those patients to go untreated we would be lacking entirely in the prevention of cerebrospinal syphilis, or inherited syphilis, because within that class of cases of latent syphilis there must of necessity be numbered those many individuals who 3 or 4 years previously have had their chancre, and who ten years hence will develop cerebrospinal syphilis. There must also be included in that class of cases that large number of young women who are in the child-bearing period, and who will ultimately give birth to syphilitic children. Consequently, in leaving that particular class of latent syphilitics go untreated, we are inviting more cases of cerebrospinal syphilis and inherited syphilis.

I do not believe it is correct to assume that syphilitics in the latent stage cannot be treated successfully. In the last year and a half I have had the privilege of treating somewhere between 150 and 200 cases of syphilis, and at least 50% of those cases have been cases that have fallen into the so-called latent class. They were individuals who gave a history of syphilis (if they recognized their chancre), some 3 or 4 years previous, being Wassermann positive, and without any external manifestations of syphilis. Without going through the records I can safely say that at least 25% of those latent syphilitics have become Wassermann negative from their first course of treatment which consisted of six injections of arsphenamine, and four months of mercury. Without going further, it seems to me that such results are enough to warrant an intensive, prolonged treatment of these tertiary cases, regardless of the fact that they are not active, the treatment being not so much for the individual himself at the time, but for the prevention of cerebrospinal and inherited syphilis later.

I should like to register a protest against one method of treatment not mentioned in Dr. Seelman's paper, and that is the so-called Protiodid of Mercury treatment of syphilis. I firmly believe that mercury tablets have done more harm in the treatment of syphilis than good. I doubt very much if there is a case on record in which the Wassermann has become negative, let alone the individual cured, with nothing but Protiodid of Mercury Tablets. Certainly Protiodid of Mercury is not the most effective means of treating syphilis. All too frequently individuals are given to assume the fact that Protiodid of Mercury Tablets are going to cure them, and consequently neglect other forms of treatment. That is why I think they do more harm than good in the treatment of syphilis.

Dr. Daniel Hopkinson, Milwaukee: Mr. Chairman and Gentlemen: I am sure that this paper of Dr. Seelman is very timely, and has covered the subject in such a manner that all might benefit from it. In that syphilis is with us all the time, and in an unrecognized stage, I believe it was an imposition on the intelligence of the medical profession to have a man like Symmers reach such conclusions as he did, and publish them on such insufficient data, relative to the Wassermann test, and the existence of syphilis in bodies, either anti or postmortem. His records, as shown by his published paper, I do not think would stand the test of any one pathologist, or otherwise, on which to base a conclusion and it was well that Warthin then wrote in answer to this such an apparently exhaustive and scientific paper relative to the frequency of syphilis. While Warthin may have taken an extreme viewpoint, the fact remains that even in a large percentage of his 40% he was able positively to prove that syphilis was present. This attitude, I believe would be much better for the profession than the other attitude, which would lead to a neglect if our present-day methods of diagnosis were derided. We do know that in cases of absence of clinical evidence there is only one evidence that we can intelligently interpret, if we are so far developed, and that is the Wassermann test. We must take its value for what we know it is worth today, because it is the best that we have. It is only a link in the chain of evidence, but it is often the link that decides the matter. Its errors and its values must be well weighed with the clinical evidence, even though it is only the deciding point. As Dr. Seelman has said, it is not an index of the presence of immune bodies, but it is probably an index of the production of by-products that occur in certain amounts only in the presence of syphilis. And therefore, if our test is sufficiently broad, and not too delicate, that amount would strongly suggest the presence of syphilis.

As to the treatment of syphilis, I do not know anything about it. I have no records that would be sufficiently valuable to speak on that subject. Such as has been told to me by men that have treated, has been so varied, that I could never come to any conclusion as to which was right, and which was wrong. However, there is one thing that I have noticed, and it is that men, whether specialists or otherwise, look at a Wassermann fast reaction as the specialist and the general practitioner looks at a case of gleet: he would like to get away from it; he does not want to keep it; he wants to persuade himself that his man is all right, and wants to tell the fellow that it is a catarrhal condition that does not need any treatment, and he does not want to

be continuing along the line of treatment. I believe, as Dr. Sargent has said, that if it is going to be any index at all, there isn't that exception, and if Warthin is correct in his statement, and it will probably be correct in a large percentage of the cases, there is no time so far that we have definitely accomplished the fact of an absolutely cured syphilis. He says that he has found otherwise in all those cases with recent proliferative change is every one of the cases that he has had. We know, of course, that some of that recent proliferative change in the tissues which he found in them may not have been syphilis; but at the same time it is a warning, as Dr. Seelman has said, to continually keep that individual under observation, just as you would a tuberculosis patient. It is a warning to keep those things that we have as an index of what we consider a cure in such a subjected position that at least we think we are doing the best that we can for that patient.

Dr. O. M. Layton, Fond du Lac, Wis.: I should like to say that I have listened to Dr. Seelman's paper with a good deal of interest and satisfaction. In fact, the paper is so good that I do not make any attempt to criticise it, but rather I should like to emphasize nearly everything he has said. I can remember back 25 years ago of hearing our teachers tell us to regard every patient as syphilitic until proved otherwise. I went out into rural practice and forgot that admonition for a few years, until I got wise, and I have come back to the old teachings and regarded every patient as a possible syphilitic until proved otherwise.

I do not think that we make as many Wassermanns and other tests as we should. They are easy to make, or at least it is easy to make preparations for others to make the tests, and I think we ought to make them more often, and then we will make fewer mistakes. I recall just now the case of a very prominent lady who had been the rounds of not only several physicians in her own city, but some in the surrounding cities, and in fact had been in a sanitarium for a period of 3 or 4 months. She had been a widow for ten years. I saw her only 2 or 3 months ago, and it occurred to me it might be well to make a Wassermann test, and the test proved 3+ positive. I do not think that we make these Wassermann tests as often as we should. It is like making the rectal examination. I remember one doctor who said that he would make a rectal examination of the patient as soon as he entered the office, because if he did not do so he might otherwise forget it. I think in a great many of our suspicious cases that we put down as neurotic, or suffering from hypertension from unknown causes, we should make the Wassermann test, and if that does not satisfy us, go ahead with the spinal fluid test.

Dr. A. E. Bachhubber, Mayville: I should like to ask Dr. Seelman what he would consider an intensive course of mercurial treatment?

Dr. H. P. Greeley, Madison, Wis.: I had the pleasure of hearing Prof. Warthin in New York give the Harvey lecture last winter, and it was very interesting to see him throw his bomb into the quiet seclusion of the well-entrenched pathologists there. I think the importance of what he did does not lie so much in the total percentage of cases of syphilis that he claims to have discovered in the rural population of Michigan as it does in his methods of work. He pointed out very well there that if you go to any text book on pathology or any treatise on medicine, you will find that syphilis is studied from the point of view of a skin disease, or the point of view of the gumma, and the time has come when syphilis can not be studied by the pathologist under those heads alone; that it must be discussed and studied as a disease of all the organs of the body, and not merely from the point of view of tertiary gummatous lesions and the point of view of skin lesions. And although there is plenty of controversy over Warthin's results, I think the important thing is that he has thrown new light and introduced new methods of study in syphilitic pathology.

Dr. J. J. Seelman, Milwaukee: I think the speakers that followed Dr. Sargent have answered his criticism as well or better than I could answer it. Dr. Sargent evidently did not get the essential point I tried to bring out in my paper. That undoubtedly was the fault of the paper rather than his fault.

As to the value of the Wassermann test I might say that, though I am a laboratory man and make part of my living doing Wassermann tests, I have always tried to warn physicians against relying too much on this test. I have done this not because I consider the test unreliable, but because I think the physician should not depend on it alone in making his diagnosis. In arriving at a diagnosis he should use all the diagnostic methods at his disposal. The Wassermann test is only one of these methods and it may or may not aid him in reaching a correct conclusion. There are unquestionably many cases of latent syphilis, as I have pointed out in my paper, that do not give positive reactions.

And I should also like to add to this a warning not to depend too much on the Wassermann test as a guide in treatment; that is, it should be used, but not be depended on altogether. Undoubtedly, Dr. Sargent got a good many negative Wassermanns in the cases that he had treated intensively in the tertiary stages, but neither he nor anyone else knows whether these cases were cured; and in the light of our modern knowledge of the pathology of syphilis, the chances are that very few were really cured.

The point that I tried to emphasize most in my paper was that no single method or system of treatment is applicable to all cases of syphilis. The treatment must be varied in accordance with the stage of the disease, the symtomatology and probable pathology present, and lastly the idiosyncracies of each individual.

In answer to the question, what constitutes intensive mercurial treatment? I would say that this, too, depends on the patient. Some can stand much more mercury than others. In a general way an intensive course would be one carried out over a period of 5 to 6 weeks, keeping the patient just below the point of salivation during this time. This can be done either by the injection of soluble or insoluble preparations, or by the use of inunctions. The Germans, I understand are com-

ing back to the inunction method, and seem to think it has shown itself superior to the intramuscular method. If this is true, and if experience bears out the experiments of Schamberg and his co-workers regarding the efficiency of calomel ointment, this method will constitute a most ideal way to administer mercury.

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ATROPIN AND DEXTROSE SOLUTION IN TREATMENT OF ACUTE INTESTINAL OBSTRUCTION.*

BY A. J. CAFFREY, M. D.,

MILWAUKEE.

This paper deals with a subject which is rarely left completely in the hands of the internist because we have always felt that acute intestinal obstruction endangers the life of the patient in such a short time that operative interference is necessary and the patient is turned over to the surgeon. During the last six months, however, I have had two cases, which, owing to certain circumstances were left entirely in my hands and which I will report in this paper later on. One of my cases I wish to emphasize on account of the grave toxic aspect which it assumed while the other run a milder course of the disease. While we know that two cases do not prove a very great criterion of any treatment, I can only say, like the Irishman, who said: "This is a hell of a war but it is the only war we've got."

I have no desire or wish to discredit surgery in any way as it is essential in all acute intestinal troubles to call in consultation a good conservative surgeon.

I will not go into the pathological etiology deeply since they are well known to most of you or I might say known as well to most of you as they are to me.

We usually have a history of constipation or chronic impaction in the lower bowel, or we may have a history of a former operation or peritonitis causing bands of adhesions. We may have an irregular peristalsis in a circumscribed area of the intestine which especially in children may produce an intussuseption. Strangulation may occur from the bands of adhesions or the end of Meckel's diverticulum which is usually free, may be adhered to the abdominal wall, and a loop of bowel may be caught and constricted. Again, a portion of the bowel may be forced through a slit in the omentum or mesentery or into peritoneal diverticulae and openings producing what is known as "Treitz retroperitoneal hernia." We may have also a diaphragmatic strangulation and last, but not least, we may have a volvulus or twist in a loop of

*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, October 2, 1918.

the bowel. This occurs most frequently either at the sigmoid flexure or in the region of the secum. McGlannan in the Journal A. M. A., August 21, 1915, has classified acute intestinal obstruction into three stages, stage of onset, stage of compensation, and stage of toxemia, but the danger lies in the fact that these three stages may occur within twenty-four hours, after which time operative measures produce as high a mortality or even higher than a "watchful waiting" measure.

Auspach in the Journal A. M. A., Sept. 17, 1918, says: "It is probably true that if all cases were operated on in the first stage according to McGlannan's Classification all or nearly all would be saved, but we would have many unnecessary operations performed and some mortality from operative interference."

This is one reason why the surgical mortality is so high; the fact that after twenty-four hours or more irreparable damage may be done to the intestinal walls and the patient may be in the last stages of toxemia when he reaches the operating table. So it behooves the internist to develop a better accumen in the diagnosis of this grave condition before irreparable damage is done.

I was fortunate in both my cases not to have a gangrenous bowel or some other grave complication arise, and I attribute it to the fact that the circulation in the intestinal wall was not entirely constricted even though it proved to be a volvulus in both cases in the region of the secum. I was lead to use atropin in the treatment of those cases from the writings of Eppinger and Hess whose monograph series No. 20, New York, 1915, is published by the nervous and mental publishing company under the title "vagotonia." They claim that atropin is the best antidote in all spastic states. Also I had in mind a patient some years ago practically moribund from hiccups that persisted eight days resisting all treatment, and on the advice of Dr. Louis F. Jermain, who was my consultant, I gave 1-50 gr. of atropin, the hiccups stopped, and the man was nursed back to health. By way of digression I will say that I published this case in the Journal of A. M. A., June 14, 1913, and had a letter from a physician down in Tennessee thanking me effusively and claiming the article saved his life.

I got the idea of using dextrose after hearing Major Lawrence Litchfield, Chairman of the Medical Section, read a paper entitled "Dextrose Intravenously as a Therapeutic Measure" before the Medical Section at the A. M. A. meeting in Chicago this last summer.

Case 1. Mr. J. M. Age 54. A clerk, married, no children; weight 135; height 5 ft. 6 inches; a thin wiry little fellow of a nervous type.

F. H. Negative.

P. H. Denied all the usual childhood diseases, also denied venereal troubles, said he was never sick, but was always constipated.

Present Complaint. I was called on June 5th this year and found him suffering excruciating pain in the lower right abdominal region. He said he drank a few glasses of whiskey the day before but he showed no effects of it on my first visit, that is, he was sober. He said his bowels had not moved since Decoration Day and he marched in the parade on that day. His pain came on suddenly after straining hard to get an evacuation. To use his own words, "Something happened low down in his belly suddenly, after straining for an hour to get a movement, the pain doubled him up, and he said he almost fainted, cold beads of sweat stood out on his forehead, the pain even running down to the head of the penis which would mislead one to suspect a concretion in the ureter. It was extremely difficult to differentiate his trouble from appendicitis or from a calculus lodged in the ureter. Owing to the intense spastic rigidity of the abdominal walls I could make out nothing definite; his suffering was so terrific that I had to resort to a hypo of morphine and atropine. I attempted to get an evacuation by giving an enema of normal salt solution and olive oil, using a large sized male catheter attached to a fountain syringe, but the result was only a few hard scybalae about the size of so many hickory nuts. Two ounces of liquid petroleum was administered by the mouth without any result. When I called again the same day condition was the same except the false relief he got from the hypo. On June 6th I found he had a restless night, vomiting twice during the night, I suggested calling a surgeon and taking him to the hospital, but for some reason neither he nor his wife would listen to it. He suffered so much on the sixth of June that I called again and repeated the hypo, and enema, but I got no result from the latter. June the 7th, 8th, 9th, 10th, 11th, 12th, 14th. His symptoms run about as follows: Temp. run between 104½ and 95. His pulse be-

came thready, irregular and paradoxical in type. His blood pressure even was irregular. I could get the systolic taps at 190 and they would disappear at 185 and come back again at 165 and disappear again at 150 and come back again at 140 and disappear again, so that his real diastolic pressure was finally found to be only 70. There was extreme restlessness with continued jactitation, there was exaggerated peristalsis in the upper bowel and borborygmi could be heard, he had localized peritonitis with some tympanites with extreme tenderness all over the belly. I kept on injecting atropine 1-50 gr. twice a day and after the fourth injection I could make out a large mass in his right hypochondriac region, by this time he was camatose and on his wakeful moments delirious at times. He said there were too many flies flying before his eyes. He developed stercoraceous vomiting of the coffee ground type. Under the relaxing influence of the atropin the mass in the right side was made out to be the distended cecum. As days went by he became extremely dehydrated and cadaverous looking from the continued vomiting and the toxemia. He developed the well known facies hippocratica, and both my surgical consultant, Dr. R. G. Sayles, and myself, thought it was all off. Dr. Sayles kindly offered to operate earlier in this case but owing to his poor prognosis his services were refused. While at the A. M. A. meeting in Chicago I heard Major Lawrence Litchfield read a paper on dextrose solution in dehydration, so I returned the same evening and in addition to the atropin I gave 500 c.c. of dextrose solution, 25% strength, intravenously, using the ordinary arsphenamine outfit, sterilizing the glucose solution first by boiling. I left my patient in the hands of a male nurse and returned again on the 14th and repeated the dextrose and atropin after which he seemed to lose his delirium and look a little brighter. I then gave him the glucose solution by the Murphy drop method and after twelve to fourteen hours of this drop method he passed the tube with a large scybalum followed by a large amount of soft feces of an intensely offensive odor. This was the first evacuation he had since May 30th. His abdominal symptoms disappeared after the evacuation, his mind cleared up and his heart became more regular, nausea disappeared, he began to retain liquid nourishment and gradually regained his strength and he is now well and returned to his work. His urine was examined twice and showed nothing more than an increased amount of indican.

Case II. Mrs. G. W. Age 50, married, no children. I was called June 29th and I found her suffering intense pain in the lower right side, she said she could not stand up and it came on her suddenly while she was trying to put up a curtain that was pulled off the roller.

She gave a history of having sores on her legs which left many brownish discolored scars. She claimed they persisted even though she took medicine for a long time. She claimed that her trouble this time was like that of five years ago when she was taken suddenly with a pain and lump on her side which she thought was a tumor or abscess; she said she was always constipated and strained hard sometimes to get her bowels to move. At that time five years ago her condition became so bad that she was taken to St. Mary's Hospital and was operated on by Drs. Frew and Fox but there was no tumor. However, they found a twist in a loop of the bowel. I am giving here my patient's own words. Her urine was negative. Blood examination was not made. Examination revealed a mass on the right side of the abdomen with some tenderness all over the belly and a local peritonitis on the right. Inspection revealed what might be called a lopsided belly. The peristalsis was exaggerated in the upper part while the lower bowel was spastic and right abdomen rigid. Her pulse was slow but regular and her temperature was subnormal. Her pulse was 58, temp. 96. She was suffering continued pain which became cramp like at times. She had not had an evacuation of the bowels for four days. I tried a soap suds enema with no results. I then gave her 1-50 atropin twice a day and after two days the rigidity of the abdominal muscles let up but I could feel the distended secum which kept up its spasticity and making the belly still lopsided; on account of a former operation I felt that the bowel might be caught in some bands of adhesions but afterwards I found this not to be the case because the mass under the influence of atropin became very mobile and began to soften up, but still I could not get an evacuation and cathartics only made the condition worse. I continued the atropin twice a day for four more days after which all abdominal symptoms disappeared and after a high enema of olive oil and salt solution her bowels moved copiously and she regained her strength and is now entirely well.

In conclusion I wish to state that this latter case did not reach the extreme toxic or dehydrated condition as did the first, and although she was nauseated, she only vomited a few times. I made a fluoroscopic examination of this patient since and find that she has an exaggerated gastro-enteroptosis, her stomach after giving a barium solution looks as though it was away down behind her bladder.

Neither of these cases showed any signs of atropinism outside of dilatation of the pupils.

From my limited experience I am firmly of the belief that no matter what the cause of the obstruction may be the condition known as vagotonia prevails and atropin is indicated no matter whether the case is in the hands of the internist or in the hands of the surgeon. I will say, too, that both the surgeon and the internist have many cases in which the use of dextrose solution would be life saving, and we owe a debt of gratitude to Major Litchfield for his splendid paper read before the medical section and published in the Journal A. M. A., August 17, 1918.

DISCUSSION.

Chairman (Dr. L. F. Jermain): This paper of Dr. Caffrey is now open for discussion. Is there any discussion of the paper?

I promised Dr. Caffrey I would say a few words in discussion of his paper, and I hope some of you will take up the discussion afterwards, because, after all, the discussion that we elicit in these meetings is often of greater value than the paper.

In handling this type of cases, of acute obstruction of the bowels, an important matter always is to determine, if possible, whether you are dealing with an occlusion of the bowel, or with actual strangulation. There is a world of difference between the two. You may have an occlusion of the bowel that will give you a picture almost the same as that of strangulation, except that the patient is not shocked to the same degree; there is not that rapid toxemia that you find in strangulation, and the therapeutic results from the administration of motor nerve depressents, such as atropin, physostigmine, and other substances, are distinctly beneficial.

I have some doubts as to whether Dr. Caffrey's cases, at any rate the latter case that he reported, was strangulation of the bowel in any sense of the word. Any hollow viscera that is supplied with smooth muscle fiber, and that had longitudinal and circular muscle fibers will contract on an offending body, that is, a spastic condition will result. That is normal physiological action. Now that is what occurs when you have an occlusion of a bowel, be it through fecal impaction or any other cause; you have a spastic condition, the result of contraction of the circular and longitudinal muscle fibers. It is in that class of cases particularly, where atropin is of great value. The atropin relaxes the bowel; it relaxes the viscus; it acts by stimulating centrally the cerebral and the medullary centers, and at the same time it paralyzes the nerve endings. Atropin is a stimulant centrally and a paralytic peripherally. It relaxes particulary the smooth muscle fibers of the hollow viscera; it paralyzes the third nerve; it depresses all secretions. So that in atropin we have a remedy of great power, particularly for the relief of spastic conditions of hollow viscera. For instance, pylorospasm can be relieved almost immediately by atropin; also spasm in the intestinal tract anywhere; and when we have a case where there is bowel occlusion, where there is bowel obstruction, without actual strangulation, atropin is indicated, because by relaxing the spasm we allow normal peristaltic waves to be resumed. Normal peristalsis is a combination of stimulation and depression—normal peristalsis is a co-ordinated purposeful action; contraction is followed rhythmically by relaxation, and it is the combination of contraction and relaxation that constitutes normal peristalsis. Now by relieving spasm by the administration of atropin we get restored normal peristaltic action.

FROM A MEDIC OVER THERE.

Do you recall those happy days
We sat before the log fire's blaze,
Within our little parlor snug,
With Shep asleep upon the rug,
And heard the clock tick on the shelf—
Except when Shep would scratch himself?
And there were times, with sudden rip,
He'd bite himself upon the hip,
Then turn his head in manner queer
To scratch himself behind the ear;
Then, like the whirling of a gale,
Get up and madly chase his tail.

Well, dad, I do not want to brag,
But since in France I've served the flag,
I'll say in running down a flea,
Shep never had a thing on me.
In fact, I think I've learned to do
Some twists our old dog never knew.

We used to scold and put him out,
We would not let him stay about
When he began to thump the floor;
But, oh, when I get home once more,
I'll let Shep scratch the evening through,
Because, you see, I've had 'em too.

—*Exchange.*

The dung of doves is a very certain help for the gout, when applied mixed with boiled barley in white wine. (Mizaldus.)

A NEW INCISION FOR APPENDECTOMY.

BY LEIGH F. WATSON, M. D.,

CHICAGO.

Many writers have noted that in the cadaver the base of the appendix is found at McBurney's point, while in the living subject it is below this point, usually on a level with the center of Poupart's ligament. A number of operators have called attention to the ease with which the appendix can be removed when operating for right inguinal hernia. Since 1910, I have used a new incision, with its center over the base of the appendix, and believe that in many cases it is an improvement over those in general use.

Incision: A point one and one-half inches from the right anterior superior spine, on a level with a line connecting the two superior spines, is selected for the beginning of a vertical incision which extends directly downward for two to three inches to a point just above, and to the inner side of the internal abdominal ring.

Advantages: Traction to expose the appendix is avoided, because this incision, in the external oblique and its aponeurosis, the most resistant structures, is directly over the base of the appendix. It can be enlarged without weakening the abdominal wall. The ilio-hypogastric and ilio-inguinal nerves are not injured because the incision lies between them. Because this incision is made over the cecum, the small intestines do not crowd into the wound as they do when the McBurney and lateral rectus incision are used.

ON THE PATIENT SECRETARY.

There is nothing so good as a good secretary. The better they are the more we impose upon them; and, strange as it may seem, the more we can impose upon them, the more we love them. I never see a patient secretary chasing around after a member's dues that I do not think of lazy Sam Snow and his patient wife. One day this colored lady looked up from her washing and said to Sam, who was idly smoking:

"Sam, man, I don't think you loves me any more."

"Nonsense, honey," Sam said, "what makes you think dat?"

"Why, you jess sits there by the fire all day long and sees me work."

"Why, Liza," Sam explained, earnestly, "the more I sits here and sees you work, the more I loves you."

That's how we love our secretary. And, like Liza, the patient secretary falls for it.

SAM YANK, M. D.

It look as if our Uncle Sam
  Had best hang out his shingle
To dole out economic pills
  For ills complex and single!

We've licked the everlasting hide
  Completely off of Prussia—
And now it seems we've got the job
  Of pacifying Russia!

The Czecho-Slavs—the Jugo-Slavs
  The Poles and Turks—it's funny—
Want constitutional advice,
  And food, and clothes, and money!

The nations old—the nations young—
  Are clamoring for assistance
They seem to follow, one and all
  The line of least resistance.

From Uncle Sam to Dr. Sam
  Is not a hard transition
When all the world has come to know
  He is the best physician!

—*Milwaukee Journal.*

AN AMBIGUOUS LOCATION.

He was sitting by her side at dinner, proudly congratulating himself upon being where he could look down upon the beautiful neck and arms.

"I am being tortured," she said, as she moved uneasily. "I have been vaccinated, and it is just 'taking'."

"Why," he said, unguardedly, as he cast another glance at that handsome neck and those lovely arms, "where were you vaccinated?"

"In Boston," she replied, as a smile drove away the evidences of pain.—*Ex.*

The following came from Oklahoma put up in abnormal salt solution: Mrs. True, married, age thirty-five, stuck a needle into the middle finger of her left hand. On the advice of her family physician she left it alone. Sixteen months later she gave birth to twins and one-half of the needle was found in the corresponding finger of each child. It was Mrs. Dooly who said: "Twins to bee wan of thim misfortunates as niver comes singly." —*E. S. McKee, M. D.*

A woman, dirty and disheveled, went into a public dispensary with her right arm torn and bleeding. As the surgeon bathed her wound preparatory to binding it up, he asked, "Dog bite you?"

"No, sorr," the patient replied, "another loidy."—*Everybody's.*

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EDITORIALS

STEREOROENTGENOGRAMS OF THE INJECTED LUNG.

W. S. MILLER of the University of Wisconsin publishes an important paper from the Tuberculosis Laboratory of the Johns Hopkins Medical School and Hospital, showing that by means of differential injection masses the relation of the pulmonary blood vessels to the bronchi and to each other can be demonstrated in stereoroentgenograms of the lung. This method of study also possesses the advantage of showing the relation of the bronchi and blood vessels to the lobation of the lung, a point not always brought out in corrosion preparations.

In its gross distribution the pulmonary artery is situated posterior (dorsal) and slightly lateral to the main stem bronchi while the pulmonary vein is situated anterior (ventral) and mesial to the main stem bronchi. In their ultimate distribution the branches of the pulmonary artery are closely associated with subdivisions of the bronchial tree while the branches of the pulmonary vein are situated as far as possible from the bronchi. The interweaving of the artery, bronchus, and vein which takes place along the periphery of the lung is to be differentiated from the hazy, smoky areas which are present in the early stages of tuberculosis.

Attention is called to the apparent change in the relation of the artery and vein to the bronchus due to the natural curvature of the lung.

The sharp ring-like shadows which are frequently seen in the middle third of the lung are often due to the plane which the bronchi bear to the observer, but when these shadows are broad with irregular, hazy borders, they are cast by bronchial cartilages.

Three stereos, which can be removed for study, accompany the paper and assist in bringing out the descriptive text by which they are accompanied.

Prof. Miller's work has been shown in the University Extension courses given through the state by Dr. Rinker. These are available for county societies and groups of physicians during the coming summer.

DRAFT REJECTS.

NAMES of men rejected by local draft boards on account of tuberculosis are now being sent out from the office of the National Association to state associations. The National Association has a stenographer at work in the office of the Surgeon General at Washington copying these names. There will probably be 60,000 or 70,000 of them. The names are being distributed as rapidly as possible.

The following information is being given on each card: name, date of rejection, number of the local board, the sanatorium or hospital at which the man was treated, if at all, and the diagnosis indicated as the cause for rejection. It has been impossible to secure further information than this because the records of the draft boards do not give it. The National Association has prepared a circular explaining the entries on the record cards being sent out and will send a copy of it to any association that is unable to interpret the records.

The attention of tuberculosis associations is called to the fact that these men rejected by local examining boards are not subjects for Red Cross care. They have not been soldiers and cannot be considered by the Government or the Red Cross as such. They are your problem, my problem, the problem of every Wisconsin community.

LATEST ETIOLOGY EXPLAINED!

THE "Pathy Doctors" have brought out one "great scientific discovery" after another. Everything from dislocated spines to dislocated gizards have been blamed as the cause of all disease. Now comes "Dr. J. Herman Hafemeister, D. N.," of Milwaukee with the explanation that "shrunken ligaments are the beginning point of all diseases to which flesh is heir." He is a "naprapath" and he knows. Shades of Kirksville! are the "osteos" and "chiros" on the wrong track? Who can tell? Maybe "J. Herman" is wrong. Someone should investigate dislocated toenails. Listen to this from the Milwaukee Sentinel of Feb. 9th:

"Much curiosity was aroused recently among readers of The Sentinel in a news story which bore the cryptic headline, 'Alleged Speeder a Naprapath,' and in the course of which Dr. J. Herman Hafemeister, D. N., was reported to have declared naprapathy a manipulative form of treatment of advanced osteopathy.

Asserting that the reporter erred slightly in quoting him, Dr. Hafemeister writes to The Sentinel, stating that what he really said was that naprapathy is a 'form of manipulative treatment advanced later than osteopathy or chiropractic.' In this connection, too, the doctor makes the following enlightening statement regarding the newer of these manipulative sciences:

Naprapathy is the new discovery that human ailments are the result of disorderly ligaments.

These disordered ligaments lie between the ribs, spinal and pelvic bones. They may be damaged by falls, sudden twists of the body, by lifting and overwork. Abuse, infection and continued use of wrong food combinations may cause damage in the structure of the ligament and make a chronic ailment of an acute one.

A disordered ligament becomes a shrunken ligament, a 'ligatight,' and hence will not fully get over the effect of the damage without special treatment, other than drugs and surgery.

It is a fact now well established that shrunken ligaments represent 'the beginning point' of almost all the diseases to which flesh is heir."

THE INDUSTRIAL SURGEON.

AT present we are hearing much on the reconstruction and rehabilitation of the disabled soldiers and sailors. The educators and physicians of our country are behind this grand movement, and it is a very laudable one. Much credit is due to those making it the success it is. Visit one of the reconstruction hospitals, see the work that is going on there and know of the effort put forth to make these soldiers and sailors back into real men and economic factors. But, I wonder if we realize that industry makes every year more physicially handicapped men than the world war made in it's four years. Who has been helping these men to reconstruct and rehabilitate themselves in order to go on with life's battles, and that is the reason why we are helping the soldier. He has life to face and perhaps he cannot go back to the job he held before he was wounded; so too the men injured in industry, his old job may not be open to him.

Is there not in this a call for real service to some of the physicians and surgeons of Wisconsin, to

specialize in Industrial Medicine and Surgery? It is not meant here to become one of the old time "Company Docs." There are men in the State who object to the term Industrial Surgeon, for the reason that they think that it is only the Society name for the same old brand.

Dr. Lanza, of Toledo, Ohio, found in his survey of over seventy of the larger Industrial Hospitals of the country that there were three types of men entering the field of Industrial Medicine and Surgery; 1st, those who are looking for a soft place for their sacral and coccygeal regions and a steady income; 2nd, those who are using it for the purpose of working up a clientele, and some ready money while doing so; 3rd, those who select Industrial Medicine and Surgery for a life's work, realizing that they are doing a big service, and make of it the success it is possible to make in any field of Medicine or Surgery.

C. F. N. S.

THE STATE BOARD OF HEALTH.

IT has long been felt by many who have given to the subject any serious thought, that the State of Wisconsin is not properly caring for the health of her citizens. While the present State Board of Health has done the best that it could, it could not, under the present organization, attend properly to all matters pertaining to the health of the general public. The task is no light one, yet it has been handled largely by a part-time incumbent. No criticism is intended for the present Board. The point is that no Board constituted as it is at present could perform the manifold tasks in the way which these tasks should be performed.

Wisconsin is a large state with a growing population and with an increasing realization on the part of its citizens that the State has certain very definite functions in regard to human health and conservation of life. So impressed are the people that their representatives in Madison are voicing sentiment in favor of increased funds for existing health agencies. There is no argument about the value of co-operation. The recent epidemic of influenza has amply demonstrated the great value to communities of active health agencies. If good for some places why not good for all places? All citizens of the State?

The modern Health Officer is a specially trained man who has taken a degree of D. P. H. (Doctor of Public Health) at some University equipped to give such a course. Public health is now recognized as a specialty of the great field of Medicine. A practitioner of medicine can no more be an efficient Health Officer than he can be a capable Internist or Surgeon. The time has now come when communities should cease to place their department of public health in the hands of any available person, lay or medical. We do not mean to say that a practitioner can not be a capable health official. For small communities his work has shown that he is a good official. He can take care of the community's health along with his regular work. In the large cities condition are different. The work then becomes so varied that a man's whole time is required. Problems are more complex and the specially trained man is now the one who should be the Chief Health Officer. If it seems necessary to have a specially trained full-time man in the large cities how much more necessary does it become to have an expert full-time man as head of the health activities of the State?

Wisconsin needs a State Department of Health organized to care for the health of her people in the most efficient manner. No sensible person will deny this. Is the State big enough to require a full-time man at a salary commensurate with the size of the work, or is the State still a provincial group of benighted persons who look upon health as something purely personal with no relation to their fellow men? If the State lives up to its ideals there is but one answer to the question.

We doctors should never lose sight of our function as teachers of the public in matters relating to health. We should not be lobbyists for any bill but should only lay the facts before our law-makers and so place the responsibility squarely upon shoulders where it belongs.

The essential facts, as the writer sees them, are that Wisconsin needs a reorganized State Department of Health headed by a full-time specialist in Preventive Medicine with funds sufficient to carry out a comprehensive program. We can advise no less. This is the time to give this advice to our legislators. The legislature has shown willingness to appropriate funds for increased work. A bill now before the legislature provides for a full-time state health officer. That is a good start. The bill should pass. In other states similar tendencies are showing. Wisconsin should be in the van not in the rear in this fight for the betterment of the health of the people.

L. M. W.

THE JOURNAL CLINIC

Edited by
L. M WARFIELD, Marquette University
and
J. S. EVANS, University of Wisconsin
(Address all communications direct to the editors)

CLINIC OF DOCTOR WARFIELD.

Case 1. This patient was a young unmarried man twenty-five years old, who was admitted to the Milwaukee County Hospital on Feb. 7, 1919, complaining of "tightening up" of left side and face with inability to work. The family history is negative. He is the youngest of twelve children and has been more or less spoiled. Except for typhoid fever when nineteen years old he has never been seriously ill. He has had gonorrhoea twice, no complications and a "soft" chancre with no bubo and no secondary symptoms. He has done various kinds of work, the last being in an ammunition factory for fourteen months up to Oct. 28, 1918. He relates that there was red dust over everything and conditions in the shop were not sanitary. He uses tobacco and beer in moderation. He knew of at least two fellow workers who had had "brass workers ague" during winter of 1917-1918 and one fellow was said to have some paralysis of the arm, transient nature.

He says that at 1 a. m. May 17, 1918, he suddenly awoke feeling as if he were choking with gas. He got up and told others in the house that gas was leaking. He was nauseated but could not vomit and had a metallic taste in his mouth "like dirty pennies" ever since. The following day he had "swoony feelings", everything looked funny. Attacks would come on four to five times daily and last a second or two. After beginning to work with lead about Aug. 25, 1918, these attacks increased in number. He was working all the time however. On Oct. 14, 1918, he fell while at work, tripping and striking his sternum on the edge of a pail. He thought the bone was broken. No break was found and he continued to work until about Dec. 4, 1918. In the meantime he had some colicky pains coming on about twice a week. Since Dec., 1918, his chief trouble began. The left leg, arm and face "draw up", become painful and he cannot walk or use his hand. His face is always drawn slightly to the left. He cannot sleep on account of the drawing pains in left shoulder.

Physically he is a strong, well nourished man, no atrophy of muscles. Chest negative. Liver slightly enlarged, palpable. Spleen felt, edge firm. The left leg and arm are held rigidly. The fingers flexed, the thumb across the palm. Marked resistance to passive extension. The left side of the face is drawn, giving the patient the appearance of being constantly smiling. The left platysma myoides is in clonic spasms. There is a coarse tremor of the fingers of the left hand. All cranial nerves are intact. Pupils react and eyegrounds are normal. The whole left side is hyperirritable, all reflexes much increased. No Babinski. Sensation to touch, temperature, pain everywhere present, somewhat variable on the left side. No incoordination, no speech defect, or dysphasia, no Romberg sign. All passive movements of left leg and arm are resisted. Patient can walk, but suddenly draws over to left side and has to be assisted to bed.

Electric reactions are more active on whole left side. No areas of anesthesia.

Urine negative. Blood count normal. No stippling of red cells seen. Wassermann reaction, both blood and spinal fluid negative. Spinal fluid not under pressure, 2 cells, no globulin. The patient was under observation for a month. He showed no improvement. He complained of drawing pains in his shoulder which kept him awake. For several days he kept to his bed because his side "drew" so when he moved around. His appetite was excellent, bowels regular. He lost no weight.

DISCUSSION.

The diagnosis lay between a possible result of his occupation (a worker in brass and lead), syphilis, or a functional neurosis. The spasticity of the muscles without Babinski's reflex and the curious coarse tremor of his hand, together with the palpable liver and spleen suggested at first a lesion extra-pyramidal, probably in the basal ganglia of the brain. This was soon seen to be untenable. The lesion was unilateral, there was no atrophy of muscles and speech was not at all affected. Syphilis could be ruled out by the negative reactions. Such a paralysis in lead poisoning was not possible. All lead palsies are flaccid lesions, and, moreover there was no stippling of the red cells in the stained blood specimen. Chronic brass poisoning is not at present recognized. Possibly the chills which he had while at work may have been due to brass but these soon ceased, and so far as we know brass poisoning is always an acute process. No lesion in the brain affecting the pyramidal tract fibres could exist without the characteristic spastic reflexes. These were absent. What was left? Func-

tional neurosis, hysteria. He had seen and heard of paralysis among his fellow workers. After his fall this trouble came on. He expected to get compensation for injuries received while at work. The hyperesthesia, hyperirritability, increased electrical response, the irregular character of the reflexes with a negative series of findings for pathological lesions confirmed the diagnosis.

Treatment we believe will be difficult and unsatisfactory but the eventual prognosis is good for complete recovery.

Case 2. A single girl, 19 years of age, hairdresser by occupation, consulted her physician Dec. 20, 1916, complaining of pain in the left side.

The family history is interesting. Her parents are cousins. Her father was jaundiced for many years, but always enjoyed good health; the condition was not present during childhood. Mother apparently well; one sister aged 29, has had a sallow complexion for many years; aggravated at birth of a child. This child was jaundiced at birth and remained so up to age of two years when it died of dysentery. Two other sisters and a brother are apparently well. Grandfather, on father's side, was said to have had "liver disease", and was jaundiced. One uncle and two aunts also had the same condition.

The patient had measles in childhood and typhoid fever at age of three with jaundice, otherwise she has been well. Appetite good. Bowels regular. Menstrual history negative. A short while ago patient developed a cold with pains in her left side that came on suddenly and were stabbing in character. These pains were aggravated on deep respiration. There was an intermission of symptoms for two weeks, but they have again come on in the past few days, otherwise patient feels fairly well. No loss of weight. She has had these attacks of pain in the side several times before present illness.

She is fairly well developed and nourished. Skin is distinctly yellow in color. Lips and mucous membranes somewhat pale. Conjunctivae slightly yellow. Heart and lungs were negative. Spleen is markedly enlarged, reaches down to level of navel and to median line. Splenic notch felt. Inflation of the colon shows that this mass is anterior to the colon. It is hard and somewhat tender. Liver edge not felt; normal outline on percussion. No glandular adenopathy. Temperature 99°, pulse 96.

Laboratory findings:

Blood—Haemoglobin (Sahli) 58%
Erythrocytes 3,552,000
Leucocytes 6,000

Differential Count (250) cells—
Polymorphs 68%
Small and large lymphocytes 24%
Eosinophiles 1.2%
Basophils 1.6%
Transitionals 5.2%

Wassermann reaction—
Blood serum negative.
Serum bile stained.

Fragility of erythrocytes—
Beginning haemolysis ..... 0.5% Na Cl
Complete haemolysis ..... 0.46% Na Cl

The smear shows the red cells to be normal in size but slightly irregular in shape. A number of normoblasts and one megaloblast were seen in counting 250 cells. Considerable polychromatophilia present, and some basophilic degeneration of red cells with pycnotic nuclei.

Urine (Catheter specimen)—
Dark reddish—acid—Sp. Gr. 1022.
Albumen negative.
Sugar negative.
Urobilinogen and Indican +++. No bile.
Stools normal in color.

DISCUSSION.

Here was a rather unusual and interesting disease. The patient was aware that her skin was not white and that occasionally after an attack of pain in her side the skin was definitely yellow. However, she was able to do her work as a hairdresser, although, she was often tired out for little cause.

The family history, the jaundice with no choluria, but with urobilinogen in the urine, the enormous spleen and the increased fragility of the red cells of the blood makes the diagnosis of hemolytic jaundice, congenital type, certain.

Splenectomy was advised and consent was obtained from the patient. This was done. At the same time several gall stones were evacuated from the gall bladder. The spleen was difficult to remove due to many fine adhesions at its upper pole. It weighed 980 grams.

The patient developed a pleuritic effusion on the left side within two days, later a lobar pneumonia. During this time her red cells were not hemolyzed by .3% Na Cl. Urobilinogen disappeared from the urine within two weeks after splenectomy and the jaundice likewise cleared up rapidly. She recovered from her pneumonia and two years later she is well; skin white, no urobilinogen in the urine, but the red cells still show a fragility about the same as when she was first seen, viz.: be-

ginning hemolysis at .5%, complete at .44% (Normal is .42— .34% Na Cl).

CASE 3. This is a white woman 26 years old, who was brought to the Milwaukee County Hospital Nov. 16, 1918, with a recent laparotomy wound. The operation was performed four days before at Emergency Hospital, Milwaukee, for supposed acute intestinal obstruction. On entrance she complained of stabbing pains in lower left portion of abdomen.

She is married, is an actress. Her family history is unimportant. She has had measles, diphtheria and two attacks of pleurisy when a girl. She has enjoyed excellent health. About five years ago she was in a hospital for seven weeks with nervous prostration. At that time headaches were the chief complaint. Following her stay in hospital she became subject to convulsions which occurred about once a month for two years, but have gradually lessened in number. Last year she had only one attack. No history of venereal infection was obtained. She has no children, one miscarriage at four months.

In September, 1918, she was operated upon at Cook County Hospital, Chicago, for acute intestinal obstruction. Nothing was found. On October 12, she was again operated upon at Emergency Hospital, Milwaukee, for the same supposed condition. No pathological condition was found there. She recovered from both these operations but continued to have pain in her abdomen and attacks of intense abdominal tympany. The bowels were somewhat sluggish but there was no real constipation. She had no fever at any time. On the evening of Nov. 11, 1918, her abdomen became acutely distended and she had acute pain all over the abdomen, especially in the lower left portion. There was no nausea or vomiting, no collapse, no fever. In spite of the negative findings she was rushed to Emergency Hospital and again operated upon. Nothing was then seen in the abdomen to account for the pain or distension.

She entered Milwaukee County Hospital with a dressing over the abdomen and a four day old laparotomy incision. She was well developed and fairly well nourished. Her face was drawn as if in pain and she seemed acutely ill. Pulse and temperature were normal. Lungs and heart were negative. The abdomen was so distended that it seemed about to burst. Two old and one recent scars below the navel. Respiratory movements lost below the navel. The belly wall is everywhere tense and tympanitic with slight increased rigidity without spasm in left iliac fossa. This area is quite tender to light palpation. No fluid is found. There is no visible peristalsis.

Vaginal examination reveals nothing abnormal.

The urine is negative.

Wassermann reaction is negative.

The leucocytes are 7,000.

She had a stormy convalescence. There were periods of acute abdominal pain with distension alternating with periods of normal, soft abdomen. She had several apparent collapses during which the doctors in charge exhausted the possibilities of the pharmacopoea. No active drug was missed. The severe periods of collapse gradually subsided so that by the last of December she was only having alternate distension and softness of the abdomen. The bowels were always fairly regular.

An idea of her condition may be gained by the following abstract of clinical notes:

CLINICAL NOTES.

11-21-18—Patient complains of severe abdominal pain confined to lower left quadrant. Pain is continuous, remains localized and stabbing in character. Stools are not well formed.

11-22-18—Abdomen very distended and tympanitic. Gas enema given with no relief or meteorism.

11-27-18—Patient complained of severe headache, following which she became seized with a peculiar epileptiform attack which lasted about three minutes during which she became unconscious and frothed at the mouth. No muscular contractures present. Felt perfectly well after recovery.

12-2-18—Became ill with Influenza. Recovered after illness of seven days.

12-20-18—Abdomen markedly distended today. No particular discomfort. Very tender over lower left quadrant. No peristalsis visible. Atropine given with no relief.

12-26-18—Abdomen again distended. Pituitrin hypodermically gave no relief. Has regular bowel evacuations. Temperature and pulse have been normal since entrance to hospital.

1-2-19—Fluoroscopic examination made. Barium enema seems to meet with some obstruction at about middle part of the sigmoid. Passes through with difficulty and even hard to force through by massage.

Barium meal fills stomach readily. Stomach high up, lower border being opposite costal margin.

1-3-19—Fluoroscopic examination repeated shows barium, given by mouth yesterday, in large intestine. Cecum high up, normal in size, movable. All ascending, transverse, descending and first part of sigmoid flexure perfectly normal.

Rectum empty. Barium stopped at sigmoid flexure and cannot be moved by manipulation.

Barium enema given. Rectum fills readily; normal except dislocated to the right. Barium reaches point in sigmoid described above. The two cannot be made to join. Impression is of a stricture (mild) in sigmoid flexure or a marked atony of small intestine. Operation advised.

DISCUSSION.

Here was a most puzzling case. It was perfectly evident that she did not have intestinal obstruction at any time. She was seen in many attacks of pain and distension when it appeared as if she could not live, but she always came through not because of, but in spite of, enemata and various hypodermics. Hysteria was suggested on account of her previous history and her convulsion and generally neurotic make-up. This seemed to have no real foundation. Atony of the small intestines was quite apparent, but what was the cause of the atony? There was no sign anywhere of tuberculosis. Although there seemed a constriction in the sigmoid flexure it really did not appear of sufficient narrowness to account for her symptoms and signs. Moreover, the gut proximal to the stricture was not dilated.

We frankly admitted we did not know, and urged the poor girl, who was willing to have anything done, to let us look in the abdomen. She was operated upon Jan. 10, 1919, for the fourth time in about four months.

Under ether anaesthesia the abdomen was opened. The intestines were congested, somewhat distended and on carefully looking them over numerous small grayish pin head size to 2 m.m. nodules were seen scattered near the mesenteric attachment. Light adhesions were everywhere attaching the coils to one another. There was no real stricture at the sigmoid. The appendix had been removed but around the head of the cecum were enlarged glands with the grayish spots in the cecal wall. The tubes were not diseased. The intestines were all aired, replaced and the wound closed without drainage.

The diagnosis was made, tuberculosis of the intestines.

She had an uneventful convalescence except for complaints of headaches at the back of the head and occasional abdominal pain. Eight weeks after operation the abdomen is still somewhat distended but she has gained in weight and strength. The prognosis is favorable provided she is willing to take time to get well. Treatment has been fresh air and food with rest in bed. She is now beginning to walk around slowly.

MEDICAL MOBILIZATION AND THE WAR

GENERAL PERSHING THANKS THE MEDICAL CORPS.

Following is the copy of a letter dated Feb. 20, 1919, from the commander-in-chief of the American Expeditionary Forces to Col. Walter D. McCaw, M. C., chief surgeon, A. E. F.:

My Dear Colonel McCaw:

Now that active operations are at an end, and many officers and enlisted personnel are preparing to sever their connection with the military forces and return to civil life, I desire to express my personal appreciation and thanks and that of your fellow members of the American Expeditionary Forces to you, and through you to the members of your Department, for the splendid services they have rendered.

At the front and in the long chain of hospitals extending down to the Base Ports, I have watched the fine and unselfish character of their work, and the achievements which have added new glory to the noble profession they have so ably represented. Many of them have shared with the line troops the hardships of campaign conditions and have sustained casualties and privations with fortitude that is beyond praise. No labor has been too exhausting and no danger too great to prevent their full discharge of duty.

A special word of thanks is due to those members who were attached to and served continuously with the armies of our Allies. Their efficiency and high ideals have called for the highest praise of the Allied Governments under whom they have served.

Before they leave France, will you convey to all ranks under your command the deep sense of my personal appreciation of their splendid services and my regret at the impracticability of, sending each ond every one of them a letter of thanks?

Sincerely yours,

JOHN J. PERSHING.

WAX MODELS OF WAR WOUNDS.

An important work now being carried on by the Medical Department of the Army is the preparation of various lesions of the skin in wax showing the nature of wounds and diseases during the late war. Wax reproductions are being made in the Army Medical Museum by an expert of the following types of cases: chronic or unhealed ulcers following various types of wounds; unhealed lesions resulting from gas burns; unusual scar formations, and unusual skin diseases. It is the intention of the Medical Department of the Army to order patients in especially interesting cases of this character to the Walter Reed Hospital for further treatment and for the production of the models, which will be a permanent exhibit in the Army Medical Museum.

ABANDONMENT OF ARMY HOSPITALS.

With the abandonment of a number of Army camps and the concentration of sick and wounded soldiers in city hospitals, the Surgeon-General of the Army is taking steps to discontinue several camp hospitals. The base hospitals at Camps Cody, N. M.; MacArthur, Texas, and Hancock, Ga., and General Hospitals No. 18, at Waynesville, N. C., and No. 23 at Hot Springs, N. C., are slated for abandonment at an early date. In addition, it is also proposed to discontinue base hospitals at Camp Greene, N. C.; McClellan, Ala.; Sevier, S. C.; Wheeler, Ga.; and General Hospitals No. 15, at Corpus Cristi, Texas; No. 17, at Markleton, Pa.; No. 37, at Madison Barracks, N. Y., and Debarkation Hospital No. 52, at Richmond, Va. The capacity of the hospital at Camp Kearney, Calif., will be reduced to 500 beds. The Surgeon-General has recommended that General Hospital No. 33 at Fort Logan H. Roots, Ark., be changed to a post hospital, and that the post hospitals at Edgewood, Md., Arsenal, Eustis and Humphreys, Va., be made camp hospitals. No more overseas patients will be sent to any of the foregoing hospitals, except Camp Kearney.

MEDICAL VETERANS OF THE WORLD WAR.

Physicians who rendered service to the government during the world war either as officers of the Medical Corps of the U. S. Army, of the U. S. Navy or of the U. S. Public Health Service; as contract surgeons in the U. S. Army or acting assistant surgeons of the U. S. Public Health Service; as medical members of Local Boards, or members of the Medical Advisory Boards, are eligible to membership in the Medical Veterans of the world War. As previously announced, Col. F. F. Russell, Army Medical School, Washington, D. C., is secretary of the temporary organization. Those interested should write to him for forms for making application for membership. With these applications there should be forwarded $1 in payment of the first year's annual dues.

ARMY MEDICAL BOARDS APPOINTED.

Surgeon-General Ireland has appointed a Board of Medical Officers to take the subject under consideration and to make recommendations regarding the reorganization and the equipment on a peace basis, of Red Cross Base Hospitals. This board consists of Brig-Gen. Francis A. C. Winter and Cols. Paul F. Straub and Robert U. Pattison. The surgeon-general has also appointed a board of medical officers to consider and make recommendations based on reports of medical officers concerning their experiences during the war. The latter board is comprised of Brig.-Gens. Francis A. Winter and John M. T. Finney and Col. Lewis A. Conner. All these except General Finney and Colonel Conner are members of the old Regular Army Medical Corps.

BASE HOSPITAL 22 RETURNS.

Twenty Milwaukee officers who were connected with Base Hospital 22 over seas reached New York on their return from France, March 5, on board the steamship Santa Marta. The officers were sent to Camp Merrit, New Jersey, and from there ordered to Camp Grant to receive their discharges from service. The nurses with the unit were demobilized in New York. Shortly before demobilization, Major R. C. Brown and Major Francis Thompson were promoted to the rank of lieutenant-colonel, and Lieutenant J. W. Smith to the rank of captain.

Major J. M. Beffel, Major J. W. Means, Major Otho Fiedler, Captain Philipp Rogers, Captain R. T. Gilchrist, and Lieutenant R. M. Fitzgerald remained in France and will return with the enlisted men.

The following officers have returned to Milwaukee and are honorably discharged: Lieutenant-Colonel R. C. Brown; Lieutenant-Colonel C. A. Evans; Lieutenant-Colonel Francis A. Thompson; Major Henry B. Hitz; Captain J. J. Brook; Captain Wm. J. Egan; Captain O. E. Lademann; Captain F. B. McMahon; Captain J. E. Rueth; Captain Ulrich Senn; Captain Eugene Smith; Captain Edward L. Tharinger; Lieutenant S. H. Campbell; Lieutenant Geo. M. Fitzgerald; Lieutenant F. J. Schmidt; Lieutenant Walter H. Schroeder, and Lieutenant Geo. D. Siewert.

WAR NOTES

Lieutenant Gorges L. Villain of the French Army, lecturing before the dental schools of the country at the behest of the American Institute of Dental Teachers, spoke before the dental students of Marquette University, March second.

Dr. G. R. Baker who has been in service in France arrived in New York, March first. Doctor Baker was severely wounded and has been transferred to a military hospital until he is in physical condition for discharge.

Dr. Otho Fiedler of Sheboygan, who has been in service abroad with Base Hospital 22, has been commissioned a lieutenant-Colonel. Shortly before our local base hospital was ordered home. Colonel Fiedler was transferred from that unit to Base Hospital 121. He remains in France with his new assignment.

Captain A. F. Lyon-Campbell of Florence, has recently spent a brief leave of absence at home.

Lieutenant L. A. Steffen of Antigo has been recently transferred from the Belgian front to take charge of a Manchester Hospital.

Dr. Harry H. Ainsworth of Madison, with the army of occupation at Coblenz, has been promoted to the rank of captain.

Word has been received of the promotion of Captain R. T. Gilchrist to the rank of major. Major Gilchrist, formerly with base hospital 22, has been transferred to base hospital 90, located at Chaumont.

Dr. I. E. Schiek of Rhinelander, who has just returned from service in France, has been home on a brief furlough.

Mrs. J. G. Hoffman of Hartford has received word that her husband, Lieutenant J. G. Hoffman, reached the United States from France, March first.

Dr. Eugene Smith, who recently returned from over seas with Base Hospital 22, has opened offices in the Colby-Abbott Building, Mason and Milwaukee Streets, where he has resumed his practice.

Wisconsin's record for speed in the return of questionnaires sent out by the Red Cross to make a survey of nursing facilities, at the government's request, leads the five states of the Red Cross central division, with an average of 67 per cent. Many cities of the state have made a complete report, most of these being in smaller localities. Milwaukee has the largest number of nurses. The city's record shows 478 graduate nurses, 379 pupil nurses, 46 ungraduated nurses, 22 trained attendants, 87 practical nurses, 87 registered mid-wives, and 413 graduates of Red Cross classes.

ORDERS TO OFFICERS, MEDICAL CORPS, U. S. ARMY.

To Fort McHenry, Md., from Camp Joseph E. Johnston, Capt. B. F. Hoyt, South Kaukauna.

To report to the commanding general, Western Department, from Camp Cody, Capt. M. C. Crane, Osseo.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to Fort Sheridan, Ill., from Camp Custer, Lieut. I. E. Levitas, Green Bay.

To Camp Sheridan, Ala., base hospital, from Camp MacArthur, Capt. O. A. Nelson, Park Falls.

To Camp Upton, N. Y., base hospital, from Fort Porter, Capt. S. G. Pake, Haywood.

To Chicago, Ill., from Camp McClellan, Lieut. D. H. Wittie, Hartford.

To Denver, Colo., from Camp A. A. Humphreys, Capt. L. H. Flancher, Lomira.

To Fort Des Moines, Iowa, from Camp MacArthur, Capt. F. W. Aplin, Waukesha.

To Washington, D. C., Surgeon-General's Office, from Camp Dix, Major R. H. Ivy, Milwaukee.

To Camp Custer, Mich., base hospital, from Camp Upton, Lieut. H. C. Saltzstein, Milwaukee.

To Washington, D. C., Surgeon-General's Office, from Camp Dix, Lieut.-Col. N. M. Black, Milwaukee.

To Camp Grant, Ill., base hospital, from Camp Dix, Lieut. N. F. Crowe, Walworth.

To Camp Upton, N. Y., base hospital, from Camp Hancock, Capt. W. S. Darling, Milwaukee.

To Chicago, Ill., from Camp Custer, Lieut. H. F. Derge, Eau Claire.

To St. Louis, Mo., from Camp Pike, Capt. C. O. Latham, Green Bay.

To Washington, D. C., Surgeon-General's Office, from Camp Lewis, Major J. R. McDill, Milwaukee.

The following order has been revoked: To Fort Oglethorpe for instruction, Capt. I. F. Thompson, Eau Claire.

HONORABLE DISCHARGES, MEDICAL CORPS, U. S. ARMY.

R. B. Quinn, Darlington.
W. T. Clark, Ft. Atkinson.
C. F. Rehling, Fremont.
R. E. Flynn, La Crosse.
W. E. Donohue, Manitowoc.
R. P. Potter, Marshfield.
J. L. Yates, Milwaukee.
O. W. C. Maercklein, Wauwatosa.
H. M. Lynch, Allenton.
W. F. Baker, Birnamwood.
F. V. Brown, Milwaukee.
C. W. Giesen, Superior.
T. J. Sheehy, Tomah.
W. B. Cornwall, Turtle Lake.
C. S. Cook, Evansville.
G. F. King, Green Bay.
L. H. Treglown, Livingston.
F. J. Woodhead, Merton.
H. S. Roby, Milwaukee.
G. P. Dempsey, Nashotah.
C. N. Stuesser, Oconomowoc.
C. A. Richards, Rhinelander.
O. T. Gunther, Sheboygan.
N. A. Peterson, Soldiers Grove.
L. M. Pearson, Tomahawk.
S. C. McCorkle, West Allis.
P. J. Merten, Milwaukee.
Jens Rosholt, La Crosse.

BOOK REVIEWS

A TEXTBOOK OF PHYSIOLOGY: FOR MEDICAL STUDENTS AND PHYSICIANS. By William H. Howell, Ph. D., Professor of Physiology, Johns Hopkins University, Baltimore. Seventh Edition thoroughly revised. Octavo of 1059 pages, 307 illustrations. W. B. Saunders Company, Philadelphia and London. 1918. Cloth, $5.00, net.

This is the 7th edition of this standard textbook of physiology. The success and approval with which it has been met is indicated by the exhaustion of this number of editions in the thirteen years since it was first published. The present edition incorporates no fundamental change in the contents, arrangement of material, or the general principles of presentation as originally adopted, though numerous additions, substitutions, and omissions necessary to bring the work up to date are noted. As in previous editions, the reader is impressed with the simple and lucid style used in the presentation of the subject and the excellent judgment shown in the limita-

tion of material selected—the author evidently always having in mind a work for beginners rather than for the specialist or advanced student.

The general scope of the work is indicated by the nine sections under which the various chapters on special subjects are arranged. These sections are as follows: physiology of muscle and nerve; the central nervous system; the special senses; blood and lymph; physiology of the organs of circulation of the blood and lymph; physiology of respiration; physiology of digestion and secretion; nutrition of heat production and regulation; and physiology of reproduction.

An appendix contains chapters on proteins and their classification, and, diffusion and osmosis.

Manual of Gynecology. By John Cook Hirst, Associate in Obstetrics, University of Pennsylvania, Obstetrician and Gynecologist to the Philadelphia General Hospital, Obstetrician to St. Agnes Hospital, Gynecologist to Mount Sinai Hospital, Gynecologist to the American Hospital for Diseases of the Stomach, Fellow of the College of Physicians, Philadelphia, with 175 illustrations. By W. B. Saunders Co., Philadelphia and London, November, 1918. Price, $2.50 net.

In the compilation, the author undertook to present the subject of the examination, local treatment, indications for operative treatment, medical, electro-therapeutic, radium and surgical treatment of the diseases of the female generative organs, female urinary tract, anus and rectum. He succeeded in an unusual degree in producing a manual which should serve as an excellent reference for medical students, recent graduates and busy general practitioners. The text shows the author to be a methodical clinician, an erudite surgeon, and an experienced pedagogue. The illustrations include a number of new ones and others copied from standard text books, all of which will be of great service to the beginning clinicians as well as to older clinicians who are called upon to give patients a graphic description of their abnormal physical conditions and the treatment required to correct them. The subject matter is well outlined in the "Table of Contents" and the "Index" enables ready and full reference. The proof-reading might have been improved upon and the cuts would have been much better had some coloring been employed. Both criticisms are undoubtedly attributable to conditions attendant upon the war. J. P. McM.

Personal Hygiene and Home Nursing, a Practical Text for Girls and Women for Home and School Use. By Louisa C. Lippitt, R. N., Assistant Professor of Correction Exercises, University of Wisconsin (In New-World Science Series, edited by Professor John W. Ritchie). Illustrated. Cloth. vii+256 pages. Price, $1.28. Published by World Book Company, Yonkers-on-Hudson, New York.

The purpose of Miss Lippitt's textbook is to explain the means by which girls and women may attain health and happiness in the present and lay the foundations for sane and vigorous lives in after years. In clearest terms it lays down practical instructions for the conduct of their daily lives. Not only are the rules set out, but the reasons which underlie them are made clear. Directions are given for preventing the spread of infection from cases of communicable disease; and instructions are furnished for the care of oneself and one's family in cases of accident or sickness. The author has given adequate treatment to the ideas that she considers most helpful to lay-readers, but she has taken pains not to go too deeply into the scientific aspects of any subject. She has desired to keep the book rather brief and for this reason has introduced only those topics on which women and girls seem particularly to need instruction. The author is now engaged in physical reconstruction work with the wounded in France. She is the daughter of a physician, and during her long experience as a nurse, she has come into touch with many of the ablest members of the medical profession. She has also had experience as a lecturer in the nurses' training schools of Washington, D. C. The practical qualities that her duties have demanded are revealed in her book.

Quarterly Medical Clinics, A Series of Consecutive Clinical Demonstrations and Lectures. By Frank Smithies, M. D., at Augustana Hospital, Chicago. Medicine & Surgery Publishing Company, St. Louis, Mo. Paper. Price $1.50.

The first volume of this series consists of the presentation and analysis of fifteen cases covering a fairly wide range of diseases. The material is well worked up, well presented and the case histories are supplemented in many instances with excellent photographs and roentgenographs. The cases are most interesting and present various problems for the diagnostician to unravel.

A very helpful feature is the description of many of the more recent bio-chemical tests.

We shall await the next volume with interest and trust that the standard set can be maintained.

L. M. W.

The Essentials of Surgery. By Archibald L. MacDonald, M. D., formerly in charge of the Department of Anatomy, University of North Dakota; lecturer on surgery, nurses' training school, St. Luke's Hospital, Duluth, Minnesota. 265 pages. Illustrated. J. B. Lippincott & Co., Philadelphia and London. 1919. Cloth, $2.00, net.

The work was prepared for the use of senior nurses and an elementary understanding of anatomy, physiology, and bacteriology is assumed. The course covers the general field of surgical diseases and the pathological changes which result. The more important surgical lesions involving special regions of the body are taken up under separate headings. The more important divisions of the work cover bacteria, infections, tumors, wounds, surgical operations, anaesthesia, bones, valvular, lymphatic, and nervous systems, and the usual divisions into regional surgery.

The author has succeeded in presenting his subject simply and in covering only the ground essential to a well trained surgical nurse. The work can be recommended to training schools for nurses and will be of interest to the average medical man.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

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HERMAN GILBERT, Madison
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2nd Dist., G. Windesheim - - Kenosha

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The Wisconsin Medical Journal, Official Publication

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Barron-Polk-Washburn-Sawyer-Burnett	Nels Werner, Barron	I. G. Babcock, Cumberland.
Brown-Kewaunee	J. F. Gosiu, Green Bay	E. S. McNevins, Green Bay.
Calumet	H. C. Krohn, New Holstein	F. P. Knauf, Kiel.
Chippewa	S. E. Williams, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	W. H. Sheldon, Madison	H. P. Greeley, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sihree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	A. J. Hovde, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	E. M. A. Sizer, Eau Claire	R. E. Mitchell, Eau Claire.
Fond du Lac	C. W. Leonard, Fond du Lac	D. N. Walters, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
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La Crosse	H. E. Wolf, La Crosse	Sara Nimocks, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Shockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
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Marathon	A. B. Rosenberry, Wausau	F. H. Frey, Wausau.
Marinette-Florence	H. F. Schroeder, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. J. Kaumheimer, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	S. D. Beebe, Sparta	T. J. Sheehy, Tomah.
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Waupaca	Fremont Chandler, Waupaca	G. T. Dawley, New London.
Winnebago	F. G. Connell, Oshkosh	H. W. Morgenroth, Oshkosh.
Wood	J. C. Hayward, Marshfield	Wm. Hipke, Marshfield.

SOCIETY PROCEEDINGS

DOUGLAS COUNTY.

The regular meeting of the Douglas County Medical Society was held February 5. The meeting was addressed by Doctor Wiesgerber, formerly a captain in the Medical corps, who served several months in France.

JOHN BAIRD, M. D., *Secretary.*

FOND DU LAC COUNTY

The regular monthly meeting of the Fond du Lac County Medical Society was held Wednesday afternoon at one o'clock at the Elks' Club. Doctor S. E. Gavin read a paper on "The Later Treatment of Empyema". The discussion was opened by Doctor E. J. Twohig.

D. N. WALTERS, M. D., *Secretary.*

FOX RIVER VALLEY MEDICAL SOCIETY.

The 31st annual meeting of the Fox River Valley Medical Society was held at Green Bay, March 6, 1919, The following Scientific program was given: "The Control of Epidemic Diseases," Dr. W. J. Boren, Marinette; "The Pathology in Relation to Symptomatology of Goiter," with stereopticon illustrations, Dr. Ernest V. Smith, Fond du Lac; "Dyspepsia," with steropticon illustrations, Dr. Louis M. Warfield, Milwaukee; and "A Plea for a Broader Conception of Preventive Medicine," Dr. Arthur J. Patek, Milwaukee.

The following officers were elected for the ensuing year: Dr. M. D. Bird, Marinette, president; Dr. J. M. Conley, Oshkosh, first vice-president; Dr. D. F. Gosin, Green Bay, second vice-president; and Dr. E. G. Nadeau, Green Bay, secretary-treasurer.

A banquet was served at the Beaumont Hotel at seven o'clock. The speakers included Doctors D. F. Gosin and George King of Green Bay, and Doctor A. J. Patek of Milwaukee.

E. G. NADEAU, M. D., *Secretary.*

KENOSHA COUNTY

A meeting of the Kenosha County Medical Society was held March 21st in the parlors of the Elks' Home, Kenosha. The meeting was addressed by Ora D. Dutcher, chairman of the committee on the Trade and Labor Council, the members of which were present at the meeting as guests of the Society. Chairman Dutcher explained a plan for securing a patriotic fund available for the extension of Hospital facilities in Kenosha. No definite action was taken on the plan.

A luncheon was served and a social time followed in the card room of the club. The meeting was one of the largest in the point of attendance in the history of the organization and showed great interest in the work of the Society.

J. F. HASTINGS, M. D., *Secretary.*

MILWAUKEE COUNTY MEDICAL SOCIETY.

The regular monthly meeting of the Milwaukee County Medical Society was held in the Hotel Wisconsin, Friday evening, March 14, at 8:30 o'clock. The following program was given: "New Method of Treating Uterine Displacements" (with lantern slide illustrations). Dr. M. L. Henderson. The remainder of the program consisted of the report of clinical cases.

DANIEL HOPKINSON, M. D., *Secretary.*

MILWAUKEE MEDICAL SOCIETY

The regular meeting of the Milwaukee Medical Society was held in its rooms in the Colby-Abbott Building, March 24. Lieutenant-Colonel John L. Yates of Milwaukee spoke on "War Surgery of the Chest".

OUTAGAMIE COUNTY MEDICAL SOCIETY.

A meeting of the Outagamie County Medical Society was held at the Appleton Y. M. C. A., March 25. The meeting was addressed by Doctor E. V. Smith of Fond du Lac on "The Pathology, Symptoms, and Treatment of Goitre". The meeting was opened with a supper at 6:30 and was attended by twenty-five members of the association.

GEORGE T. HEGNER, M. D., *Secretary.*

ASSOCIATION NEWS

CONFERENCE ON INDUSTRIAL SURGERY.

A half day is to be given to industrial physicians and surgeons at the second industrial conference to be held in Milwaukee, April 28, 29 and 30, for a discussion on medical and surgical problems in industrial work. The program begins at nine A. M. on April 29, with one of the members of the commission as chairman.

Honorable Fred G. Wilcox will speak on "Workmen's Compensation and the Physician." Doctor C. F. N. Schram of Beloit will speak on "The Scope of Industrial Medicine and Surgery." It is hoped that all physicians interested in these subjects will make it a point to be present.

WISCONSIN SURGICAL ASSOCIATION.

Preliminary Program—Sixth Annual—Clinical Session.

Milwaukee, Wisconsin,

Wednesday and Thursday, May 7th and 8th, 1919.
Headquarters: The Hotel Wisconsin.
Wednesday, May 7th, 1919.
Evening Session, 8 P. M.
Hotel Wisconsin.

President's Address.....Dr. J. F. Pember
Election of Officers.

Paper by Dr. J. M. Dodd, Ashland, Title to be announced later.

Address by an invited guest, announcement to be made in bulletin.

Thursday, May 8th, 1919.

Clinics.

The following clinics will be held at the Milwaukee County Hospital, Wauwatosa:

8:30 to 10:00 Genito Urinary Surgery—Dr. E. A. Fleetcher.

10:00 to 11:00 Orthopedic Surgery—Dr. F. J. Gaenslen.

11:00 to 12:30 Discussion of Medical and Surgical Conditions—Drs. L. F. Jermain and L. M. Warfield.

12:30 to 1:30 Lunch.

1:30 to 3:30 General Surgery—Dr. J. L. Yates.

3:30 to 5:00 General Surgery—Dr. W. C. F. Witte

Evening Session, 6:30 P. M.

Hotel Wisconsin.

Dinner and Joint Meeting with the Medical Society of Milwaukee County.

"The Care of the Wounded in the Advance Zone"—By Col. Gilbert E. Seaman.

"Surgical Work at an Evacuation Hospital"—By Col. C. A. Evans.

There will be an Exhibit of Interesting Surgical Pathological Specimens at the County Hospital.

There will be a special bulletin issued for clinics. Register your arrival immediately at the Information Bureau at the Hotel Wisconsin, and receive the bulletin and such other information regarding the meeting as is not now possible to publish.

The Street Cars for the County Hospital leave Third St. and Grand Ave. every twenty minutes; on the hour, twenty minutes after, and forty minutes after the hour.

All members of the State Medical Society are cordially invited to attend this Clinical Session.

NEWS ITEMS AND PERSONALS.

The isolation hospital at Appleton is being moved to another part of the city. It is to be remodeled and modern conveniences installed.

Dr. and Mrs. J. L. Shaw of Manitowoc have left for St. Louis where the doctor will take post-graduate work.

Thomas S. Morris, prominent Madison business man and president of the Madison General Hospital Association, died at his home of pneumonia, March fourth.

St. Mary's Hospital, Milwaukee, is defendant in a suit for $20,000 damages, instituted by one John Kosta who, while in a delirious condition, jumped from the third floor of the hospital to the ground, sustaining a fractured leg and hip.

The Scott mansion at Merrill has been purchased by the city, aided by public subscriptions for hospital purposes.

The Wisconsin Industrial Commission has adopted the suggestions of Doctor George P. Barth, director of hygiene in the Milwaukee public schools, which require that children applying for labor permits shall be required to pass a physical examination before such a permit can be granted.

Dr. W. F. Clark of Ft. Atkinson, recently discharged from two years' service as major in the Medical Corps, has gone to Janesville where he will practice with Dr. Wayne A. Munn.

The two year medical course at the University of Wisconsin stands to be abolished, while length of the course and subjects to be taught are put up to the Board of Regents in a bill introduced by the committee on Education and Public Welfare. A four year medical course is, therefore, not provided in the bill but may be instituted through interpretation of the amendment. The section of the statute which is to be amended reads: "The medical school shall consist of courses of instruction customarily covered in the first two years of a medical course." The proposed amendment reads: "The medical school shall embrace practical and theoretical instruction in the various branches of medical science and art and may embrace such additional branches as the regents may determine."

Preliminary steps will be taken at once by the bureau of public buildings and bridges, Milwaukee, for the erection of a $130,000 addition to the South View Isolation Hospital. It is proposed to build extensions 58x120 feet to each of the two wings of the present structure. These additions will accommodate 120 patients and will be used to provide for victims of social diseases.

Dr. Helen Tennies of Antigo who has been out of practice for some years has opened an office and will again engage in general practice.

The Assembly committee on public welfare has reported favorably on the Chilson bill which includes influenza on the bill of contagious diseases which must be placarded and the home quarantined. It has also reported favorably on the Bowman bill, extending the local health boards and powers of the state board to close schools, theaters, and churches and prevent crowding in stores and street cars during any indication of epidemic possibilities.

Dr. R. C. Blankenship, recently of the Medical Corps and formerly of Marion, Virginia, has located in Stoughton.

The Coe bill introduced into the legislature requires counties to provide public health nurses. Maintaining county nurses is now optional with counties, fifteen of

which employ them. The bill requires all counties to take this step.

Through the financial aid of the Milwaukee branch of the Red Cross, the number of baby weighing and measuring stations will be increased from six to sixteen.

A free dental clinic has been estahlished at Evansville.

Plans are being perfected for the new receiving unit for the Hospital for Mental Diseases in Milwaukee. The structure will cost ahout $150,000 and will be modern in every respect.

Dr. J. D. Lindores of Stevens Point will close his office and home April first and soon after that date move to Plainfield where he will make his future home

St. Luke's Hospital, Racine, has secured the residence of P. H. Conley which adjoins the Children's Hospital. This acquisition will give the hospital greatly desired and increased facilities. The building will be used as a nurses' home.

Dr. Timothy Lyman of Sacramento, California, has located in Eau Claire and will be associated with Doctors Lyman, Curtiss, Derge, and Ziegler. Doctor Lyman was formerly superintendent of the Sacramento County Hospital, California.

Plans are being perfected for the erection of a new hospital at Hartford.

The Helm and Fox Hospital Company of Beloit has brought suit against the city, claiming they suffered losses to the extent of $3,300 at the Beloit Hospital, due to the flooding of Turtle Creek in February, 1918.

Plans have been made for a free dental clinic at Fond du Lac which will be opened about the first of April. Each dentist of the city will devote a half day a month to the work.

Dr. P. H. Jobse has returned from Wilsonville, Oregon, and has again associated himself with Dr. W. C. F. Witte, 1203 Majestic Building, Milwaukee, in the practice of general surgery.

The March number of THE WISCONSIN MEDICAL JOURNAL has the following news item.

"The Stober Maternity Hospital of Madison has been taken over and will he operated by the First Methodist Episcopal Church. The church has purchased all equipment and will continue work with the same force."

The Rev. F. E. Beauchop agent of the West Wisconsin Conference of the Methodist Episcopal Church request the writer to draw the attention of the Journal to the fact that the Stober Maternity Hospital has been purchased by the "West Wisconsin Conference" of The Methodist Church and operated hy the "Methodist Hospital Association". We are suggesting this correction because physicians will be interested to know that it is not to be operated as a local institution.—E. J. Townsend, M. D.

The United States Interdepartment Social Hygiene Board, through its Executive Secretary, Dr. T. A. Storey, 1800 Virginia Avenue, N. W., Washington, D. C., announces the following appropriations from the Scientific Research Fund of the Board:

Leland Stanford Junior University Medical School

1. "Investigation into more effective treatment in acute and chronic gonorrhea," under the direction of R. L. Rigdon, M. D., Clinical Professor of Genito-urinary Surgery, and A. B. Spalding, M. D., Professor of Obstetrics and Gynecology $2,300
2. "The permeability of the meninges to antisyphilic drugs—an attempt to increase their permeability," under the direction of H. G. Mehrtens, M. D., Clinical Professor of Neurology 2,300
3. "Investigation into more effective methods of treating syphilis," under the direction of H. E. Alderson, M. D., Clinical Professor of Dermatology 2,600

Total $7,200

University of Michigan, College of Medicine and Surgery.

1. "A rearch of an improved method of demonstrating the spirochaeta pallida in human tissues," under the direction of A. S. Warthin, M. D., Professor of Pathology..... $6.000

MARRIAGES

Doctor John B. Matthews, Milwaukee, to Miss Katherine I. Robinson, Terra Haute, Indiana, at the home of the bride's uncle, Terra Haute, March 8.

Doctor Edward L. Herrick of Kenosha, to Miss Ethlyn M. Thomas of Evanston, Illinois, March 19, at the home of the bride.

DEATHS

Doctor Paul H. Dernehl died at his home, 1281 Stowell Place, Milwaukee, Friday, March 28, at the age of 40. Doctor Dernehl received his degrees at the University of Wisconsin, the Johns Hopkins University and in the European schools. He is survived by a widow and two sons. He was a member of the Wisconsin State Medical Society, the American Medical Association, the American Association of Ophthalmology, and a fellow of the American College of Surgeons. He was on the staff of the Columhia, Children's, and Mt. Sinai Hospitals.

Doctor John H. Pflueger of Holmen died of heart disease March 26. Doctor Pflueger was born in 1853 and graduated from the Starling Medical College in 1879.

Mrs. Frances Eldred Brown, wife of Doctor Horace M. Brown, died at her home in Milwaukee, March 11,

after an extended illness. She was born in Milwaukee and lived there all her life. Doctor and Mrs. Brown were married thirty-six years ago. The funeral was held from the residence with interment at Forest Home.

Doctor Henry O. Greiner of Freemont died at the Theda Clark Hospital, Neenah, March 24, following a long illness. Doctor Greiner was born in 1875 and was a graduate of the Detroit College of Medicine and Surgery, class of 1895.

THE LIEUTENANT'S COMPLAINT.

(*Written by somebody at Fort Oglethorpe.*)

From: A First Lieutenant U. Don't Know.

To: The Surgeon-General, S. G. O.

Subject: Increased Efficiency of Each and Every M. R. C.

We know not WHOM we have to thank
That we can gain no increased rank,
But his peculiar mental spasm
Engenders no enthusiasm.
Pneumonia rages as before,
Our work's the same in peace and war.

You let the semislacker go
Who'll no more march against the foe;
And yet the while you hold the men
Who'll take an M. R. C. again.
You say discharge is given first
To those whose rating is the worst;
All your rewards are for the shirk—
You penalize the men who work.

While Teuton troops were at our gates
We gladly worked at bargain rates;
But now we've soundly trounced the foe
We want to go and get the dough,
As has been mentioned now and then
By sundry eminent cabinet men.

You seem to think we wish to stay
To push a pen day after day,
And get a first lieutenant's pay,
And watch our practice melt away.
You seem to think we're reconciled
To part with home and wife and child
And give up all that man holds dear
For twenty hundred bucks a year.
If you wish the best that we can do,
Turn all your orders hind-end to.

Vertigo is an infirmity of the head, and its cure is to put in the nose at the time of going to sleep, three drops of urine. This is a proved remedy and greatly valued of many.—Petrus de Montagnana.

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and MRS. LOUISE BRAND, Milwaukee

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SANITARY WATER ANALYSIS.

The bacteriological and chemical examination of water to determine its fitness for drinking water is an accurate means of telling whether the water contains objectionable foreign matter. The bacteriological examination is the most important, because it detects dangerous pollution in a thousand times greater dilution than the chemical, and because the results show the absence or presence of bacteria which are associated in the intestinal tract of man with disease producing bacteria. The organic and inorganic compounds detected by chemical examination have not been proven to be deleterious to health when consumed in quantities usually present in water. These compounds indicate the presence in the water of decomposing nitrogenous matter of animal or vegetable origin. Above certain limits they indicate that the water supply is receiving drainage or seepage which is objectionable, because the drainage or seepage might be coming from a source contaminated by disease forming bacteria. In other words, the presence of these compounds offers presumptive evidence of dangerous pollution of a water supply. The presumption is, however, somewhat remote.

The bacteriological examination reveals the total number of bacteria, the total number of acid-forming bacteria, and the number of colon bacilli contained in each c.c. of the water. There is no attempt made to isolate specific pathogenic bacteria. The reason for this is that the pathogenic bacteria are always present in such relatively small numbers that their isolation is not practical. The result of the bacteriological examination gives only presumptive evidence as to the actual absence or presence of disease producing bacteria. The presumption, however, is not so remote as in the case of the chemical analysis. The total number of bacteria, if taken by itself, affords little, if any, more positive proof of certain dangerous pollution than does the chemical analysis. The bacteriological examination, however, goes further and picks out specific bacteria.

The method for making bacteriological water

analysis provides for separating the bacteria present into three big groups; those which grow best at 20° C. represent the ordinary soil bacteria, those which grow best at 37° C. the body temperature bacteria, and represent the bacteria which are usually found in the intestinal tract of animals, and colon bacilli, which represent fecal contamination.

The bacteria which grow at 20° C. do not necessarily represent pollution with disease producing bacteria but above certain limits they indicate potential danger, that is—the water supply which contains large numbers of soil bacteria is receiving surface washings and seepage which may at any time be contaminated with disease producing bacteria.

The 37° C. bacteria are further separated into the acid and non-acid forming bacteria, and finally the colon bacilli present. When all of this information is put together one arrives very certainly at the probability of dangerous pollution.

The most important single determination is that for the presence of colon bacilli. This comes from the fact that colon bacilli are always found in the intestinal tract of animals and, therefore, in the excreta, feces, etc., from the intestinal tract of animals. The very probable presumption then is that if water is receiving pollution from animal excreta, it is most likely that some of that excreta comes from the intestinal tract of man, and that being true, that in addition to containing colon bacilli, it may also contain typhoid bacilli and other disease producing bacteria. The sanitary significance of the colon test has been much improved lately. The test which has come recently into use separates the group of colon organisms into those of soil and those of fecal origin. This means it is possible to say whether the water is receiving contamination of soil origin or pollution of fecal origin.

The above discussion of water is based upon the fact that certain diseases are produced by bacteria which are specific for that disease. Obviously without the bacteria the specific disease is impossible. Therefore, without finding specific disease producing bacteria in water the results of the analysis give only presumptive evidence. But that is not all. In sections where the water supply is poor or unsafe, as determined by the method described, it has been proven that the people not only suffer from diseases produced by pathogenic bacteria, which may be carried in the water, but that their general resistance is so impaired that they are ready victims for any and all infections, so that so far as the presence of specific pathogenic bacteria are concerned, our tests are all presumptive, but as related to the general health and resistance to disease, they give positive information.

It is not to be understood that because these tests afford only presumptive information as to the presence of pathogenic bacteria that water analysis is any the less important. The presumption, as I have pointed out, is so strong that any water supply which does not test up to the standards required for a pure water must be considered unsafe. No one can afford to jeopardize his life and health by drinking water from a supply which is not safe.

There are a great many people who think that so long as water is clear and sparkling, or so long as it is clear and tastes well, that it is pure, meaning free from disease producing qualities. Nothing could be more erroneous. I have given in detail the method of making water analysis and something of its interpretation with the idea of emphasizing what delicate tests are sometimes necessary to determine whether or not water is safe to drink. Surely if these tests are necessary, the appearance and taste being only gross methods of determining the character and quality of water may often be very misleading.

Not infrequently the laboratories receive water samples which have been collected in prescription bottles, fruit jars and jugs of one sort or another. These samples have been collected by one who knows nothing of how samples must be collected. The bottle seldom has been sterilized before the sample is collected, and if it has been, it is usually stoppered with a cork stopper or some other sort of a stopper which has not been sterilized, or could not be properly sterilized by boiling. When samples are received in these containers no examination is made and the sender is so informed, and given the information necessary for him to have in order to obtain a water analysis. I am often censured for not examining these samples, and once in a while I receive long letters about the "red tape" that destroys the usefulness of "our" laboratory.

In order to adapt scientific methods to routine work, it is often necessary for us to adapt ourselves to the method which gives the most accurate re-

sults. This sometimes causes inconvenience and delay. Inaccurate results, however, are worse than no results.

Everyone can avail himself of an analysis of the water he drinks if he is willing to go at it right. The State Laboratory has had prepared special boxes in which to ship bottles to be used for collecting water samples. The boxes are constructed so that they have places for the bottles and a place for ice. It is essential that the samples be packed in ice and shipped as soon as possible after collection. The bottles have been sterilized so that the bacteria which grow in the laboratory will be only the bacteria to be found in the water. In the box with the sterile containers are instructions for collecting the samples. These instructions anyone can follow. By this means detail has been reduced to its lowest limit. The details given concerning the sensitive tests which are carried out in the laboratory serve to emphasize the importance of following the directions given for collecting and shipping the sample.

DRAFT STATISTICS.

The recent report of the Provost Marshall General to the Secretary of War contains some interesting statistics in reference to the number of men rejected by Wisconsin draft and medical advisory boards.

Out of a total of 90,517 Wisconsin men examined for military service, 15.25 per cent were permanently disqualified for physical reasons.

During the period of Feb. 10 to Nov. 1, 1918, the principal causes for rejection were as follows:

1. Defective heart and blood vessels..... 14.1%
2. Defective bones and joints..... 11.8%
3. Defective eyes 10.1%
4. Tuberculosis 9.6%
5. Mentally defective 7.5%

Rural and urban rejections are compared as follows: Men were selected from boards in the cities of New York, Chicago, Philadelphia, Cleveland, Milwaukee, Seattle, St. Louis, Cincinnati and New Orleans. Rural communities were selected from all states using only boards having less than 1200 registrants in the June 5, 1917, registration.

Total examined 200,000
Examined in urban regions.. 100,000
Rejected ..... 21,675 or 21.68%
Examined in rural regions... 100,000
Rejected ..... 16,894 or 16.89%

The efficiency of our local boards may be judged to a certain extent by the number of men rejected by the camp surgeon after having been accepted and sent to cantonments by the local medical advisory boards.

7.26% of Wisconsin men accepted by local boards and sent to camps were rejected at camp.

Percentage of men accepted by local medical advisory boards but rejected by camp surgeons upon examination there:

Alabama	over 14 %
Michigan	8½ %
Wisconsin	7.3%
Illinois	6.5%
Minnesota	5.8%
Maryland	less than 5 %

The national average was 8.1%. So we may say that the physicians of Wisconsin were a little above the average in their judgment as to the fitness of men for military service.

HELP OF PHYSICIANS NEEDED.

The problem of the tuberculous draft reject still remains one of the most striking revelations of the draft examinations. There is now an actual record of over 1850 Wisconsin men rejected by local medical boards for tuberculosis. The number of discharged soldiers added to this list gives a total of over 2500 homes in which there is a known source of infection revealed by the military examinations.

With the Red Cross, the Bureau of War Risk Insurance, the Federal Boards for Vocational Education, and the Department of the Surgeon General, all seeking the opportunity to aid the discharged soldier, the tuberculous reject remains a problem for public health organizations. We may almost term it a "half solved" problem, however, for the location of the case is already known. What remains to be done is the placing of each case under medical supervision. As a means to this end the Wisconsin Anti-Tuberculosis Association is prepared to supply to properly authorized

agencies or individuals in practically every community in the state with names, addresses, and information on tuberculous rejects in that community. This is made possible through the reporting of such cases to the surgeon general's office by local boards and thence to the National Tuberculosis Association. The names and information are confidential and will be given only to recognized public health officials, visiting nurses, or organizations qualified to visit the men and give them careful consideration.

Milwaukee, Racine and Kenosha Counties have served as a laboratory where experiments have been made as to the best methods of reaching the men and what attention they need most.

It has been thought best to send them to their family physicians and urge first of all a thorough diagnosis. It has been found, however, that a large proportion of the men will not take the word of the draft examiners and do not believe that they have tuberculosis. Furthermore they are so sure of it that they will not assume what they term the unnecessary expense of a medical examination. There is but one course to follow in these cases. Send the doubting man to a clinic or free dispensary, show him that it will not obligate him in any way and of course can do no harm.

This diagnosis serves a dual purpose. It convinces the man that he either has or has not tuberculosis, and also furnishes the state board of health with more accurate data. The case is then followed up by the visiting nurse or the social worker in charge and given the proper care. Pamphlets arranged by the tuberculosis association tell the man how to obtain sanatorium treatment and where he may go for such treatment, if he should have it.

The necessity for the examination is made evident by the fact that the medical advisory boards did not attempt to diagnose each case as it came up for examination. It was not their duty. They were charged merely with the obligation of determining whether the man was fit for service or not. If he was not fit, his case was dismissed. There was no attempt at any follow up unless the Red Cross chapter in his community happened to get hold of the case and took a hand in it. But in perhaps two-thirds of the communities in which these rejects live there is no means of presenting to them the seriousness of their condition.

The registration of these 2,500 tuberculosis cases has presented not only a problem but an unparalleled opportunity for the physician of the state. In almost every instance under observation in the so-called laboratory (Milwaukee, Racine and Kenosha), there are collateral cases in the home in which the reject lives. One of the first cases visited in Milwaukee county was that of a man who had been living in total ignorance of the danger of spreading the disease to others and had even been sleeping in a small room with four others, windows closed. As a result of the examination of the reject, nine other children of the family were brought under medical supervision.

With 2,500 similar cases in the state, revealed through the draft examinations, and each one a probable source of infection to the community, there is a problem put to the medical profession in which the opportunities for service are unlimited. In other words, if the tuberculous draft rejects in your community are not being reached by any local organization, there's a big opportunity for you as a public spirited citizen and as a physician, interested in the welfare of his townspeople, to get in touch with the Red Cross Home Service department and the Wisconsin Anti-Tuberculosis Association and furnish them with a knowledge of the needs of your community.

A. C. Johnson,
Department for Tuberculous Draft Rejects and Discharged Soldiers, Wisconsin Anti-Tuberculosis Association.

THE FEEBLE-MINDED PROBLEM.

Backing up the State Board of Control in its effort to hasten construction of new buildings for the Southern Wisconsin Home for Epileptics and Feeble-Minded, the State Conference of Social Work has issued a bulletin setting forth some startling facts in connection with the prevalence of feeble-mindedness in Wisconsin.

The following extracts are taken from the bulletin:

Wisconsin has a feeble-minded population of at least 13,000 according to the conservative estimate of experts. Fully 50 per cent of these are institutional cases requiring custodial care. Less than 10 per cent of them are in proper institutions.

Many parents in Wisconsin, unable to give feeble-minded children proper care at home especially in cases where there are also normal children, are begging the various social agencies to

find room for them in some institution. Chippewa Falls is always overcrowded, especially in its department for the helpless low-grades.

From 25 to 35 per cent of the criminal and pauper population the country over is mentally defective, this estimate being based on careful, scientific study.

At least 96 per cent of feeble-mindedness is hereditary. Prevention is the only solution of the problem. There is no cure. Science cannot provide missing brain cells.

The expense to the State of caring for the girl who is beginning to follow in her mother's footsteps and of the other children can be estimated. There is no way of estimating the future costliness of leaving them at large, free to reproduce their kind.

The United States Public Health Service in its fight against venereal diseases, following war revelations, calls special attention to the high percentage of feeble-mindedness among both professional and amateur prostitutes. Of 467 women taking treatment for venereal disease provided by the Michigan state board of health between March 15, 1918, and January 1, 1919, 75 per cent were found to be feeble-minded and 5 per cent insane or epileptic.

Over 3,000 feeble-minded children are enrolled in the public schools of Wisconsin. Many of these are degenerates whose presence is a menace to the moral welfare of normal children. Only 300 of the 3,000 are in special classes in different cities. Can Wisconsin afford to allow these children to become parents?

IMMENSITY OF THE PROBLEM.

13,000 feeble-minded persons in Wisconsin. (Conservative estimate.)

4,000 of these between the ages of 2 and 20 years.

520 known cases of feeble-mindedness registered by name and address in Milwaukee county alone. This list is confidential.

249 young men of draft age rejected for or discharged from military service prior to April, 1918, because of mental deficiency. (Official report.)

6,250 (50 per cent of the total number of feeble-minded) are cases needing institutional care. (Conservative estimate.)

Wisconsin cares for fully 85 per cent of its insane population in state and county institutions, the enrollment of patients being 8,156 March 1, 1919. A part of the remaining 15 per cent are cared for in private hospitals or sanatoria so that a conservative estimate gives less than 10 per cent at large or cared for at home.

Conditions are exactly reversed in the case of the feeble-minded who are a greater menace to society than the insane.

Less than 10 per cent are cared for in institutions. More than 90 per cent are at large.

OUR INADEQUATE FACILITIES.

1,150 of our feeble-minded cared for at Chippewa Falls.

69 transferred from Chippewa Falls to the new Wisconsin Southern Home at Union Grove, Feb. 14, 1919. Commitments are also being made direct.

285 recent applications on the waiting list at Chippewa Falls.

300 approximately one-tenth of the feeble-minded children in the public schools, cared for in special classes.

The Southern Wisconsin home, now in process of construction at Union Grove, has a present capacity of 108. Only a limited medium to high class able to care for themselves and restricted also to those who are not educable are being received owing to the lack of school facilities and to the further fact that but two cottages, one for boys and one for girls, have been completed.

LOOKING TO A SOLUTION.

1. The completion as rapidly as possible of the Southern Wisconsin Home for the Feeble-Minded and Epileptic at Union Grove is the first important step in a constructive program to provide the adequate institutional care that is absolutely necessary both for the control of the present menace and for the prevention of a still greater one in the future.

The State Board of Control should have the whole-hearted support of the legislature and of an awakened public in every effort which it is making to hasten construction of the much needed buildings at Union Grove and in any other measures which are essential to a more adequate control of this serious social problem.

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2. Extension of clinical examinations for the detection of feeble-mindedness and of the establishment of special classes for the mentally defective in the schools is necessary for the protection of normal children as well as defectives. Institutionalizing of high grade morons, especially the girls, when they reach the adolescent age is vitally important. It is neither just nor safe to keep normal children in the same classes with the feeble-minded.

These clinical examinations are as necessary in connection with court cases as they are in the schools. Under existing conditions where examinations are made by persons untrained in mental diagnosis or where the decision is left to a judge untrained along these lines or to a lay jury, it is almost impossible to detect and to secure proper provision for, a great number of high grade and border-line cases.

3. Adequate supervision of graduates from the special classes in the schools, of inmates of state institutions on parole, and of the entire feeble-minded population which is at large and which requires such supervision should be provided to supplement the service given by state institutions.

It is believed by social workers, in close touch with the problem that fully 50 per cent of the feeble-minded can remain with safety in the community if effective supervision is provided. Careful selection and adequate supervision are absolutely essential, however, to make this program safe for the community.

THE DOCTOR IN POETRY.

Air, "Soldier an' Sailor, Too."

(With apologies to Mr. Rudyard Kipling.)

As I was agoing 'ome to be, through a muddy country lane,
I seen a man in a ojlskin cape, atrudgin' through the rain,
'E 'adn't a match, an' 's pipe was out, an' I ses to 'im, "Oo are you?"
An' 'e ses, "I'm a doctor, the country doctor, surgeon an' midwife, too!"
Now 'e never gets paid for 'arf 'e does, an' e' does the work of two,
An' 'e isn't one of the gentlefolks, an' 'e ain't like me nor you,
'E 's a sort of a bloomin' chameleo-type, surgeon an' midwife, too.

An' I seen 'im again all over the shop, aplayin' all sorts of rags,
Like settin' a fractured collar-bone with a couple of touch-line flags,
An' the parsons owe 'im money, for their wives give 'im work to do,
Though 'e's only the doctor, the country doctor, surgeon an' midwife, too.
An' the Poor Law Board they sits on 'im, an' tries to dock 's screw,
Though 'e 'as 's bread and cheese to git the same as me or you.
They think 'e's a 'aughty philantocrat, surgeon an' midwife, too.

An' I seen 'im again with a knife an' things, and the sweat was on 'is brow,
'E was trying to mend the guts of a bloke as 'ad spiked 'isself in a row:
'Twas late at night an' 'e 'adn't no light, to see what 'e 'ad to do,
An' 'is pal was a doctor, a country doctor, surgeon an' midwife, too.
'E 'adn't got far with 'is little job, 'e wasn't but 'alf-way through,
When the bloke sits up an 'asks for a drink, the same as it might be you:
Ho! they ain't no special anesthetues, surgeon and midwife, too.

But there wasn't a call to do as you done when you 'ad the gout in yer toe,
An' you fetched 'im out in the dead of night, an' 'e 'ad six miles to go,
For you've 'ad it before, and you'll 'ave it again, and you know just what to do.
You don't want the pore old country "doc," dispenser an' staff nurse, too.
You pays 'im? What? Yes, tuppence a week, an' you're earnin' "thirty-two."
An' 'e 'as to subscribe to your football club, which you're too mean to do,
Because 'e's the doctor, the country doctor, surgeon an' midwife, too.

Now I never believes in them specialist thieves, what stammer, an' grunt, an' blow.
As 'll watch yer lie with a winkin' eye for a 'undred pounds or so:
An' when it's "Checks?" an' "'Oose turn next?"—which I 'opes it won't be you!—
Let's stick to the doctor, the country doctor, surgeon an' midwife, too.
An' when you come to the Bar of Gawd, an' 'E says "'Oo passed you through?"
(For 'e 'ates Peculiar People an' the Christian Science crew)
Just mention the doctor, the country doctor, surgeon an' midwife, too.

—*E. G. B. A., in St. Bartholomew's Hospital Journal.*

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ORIGINAL ARTICLES

"NOTES ON SOME MEDICO-LEGAL CASES I HAVE KNOWN, INVOLVING THE QUESTION OF INSANITY."*

BY RICHARD DEWEY, A. M., M. D.,

WAUWATOSA.

Cases in which the question of insanity is involved often come into court for trial. As insanity is a disease, law and medicine jointly determine the issue in such cases. These cases are of several sorts. Insanity is often claimed as a defense in criminal prosecutions. It is the basis of attempts at breaking wills and contracts, and of efforts at establishing guardianship over the estate of inebriates or spendthrifts. A spirited contest often occurs when the question arises as to committing an individual to the custody of an asylum, especially an individual who stands on the border line between the realms of sanity and insanity, who engages counsel and warmly contests the issue. Here is a "No Man's Land" which has been fought over in many a sharply contested battle with great guns and small, figuratively speaking, barbed wire, tanks, and even "poison gas" have been brought into play in these legal battles. The world has looked on for ages while these wordy wars were fought out in which the plea of insanity was urged as a defense in criminal prosecutions; for an insane man, like a king, "can do no wrong." More than a century ago, the case of James Hadfield, who had shot at King George III in Drury Lane Theatre, came before the courts and a succession of such cases of so-called "regicides" has occurred even reaching our own land and resulting in the assassination of two of the Presidents of the United States. Hadfield missed his aim and the King was unhurt, but the assailant of the King was tried for treason before Lord Chief Justice Kenyon with all the associate Justices sitting in the case and some of the greatest lawyers in England took part in the trial. I will quote from the speech of Honorable Thos. Erskine, who defended Hadfield, the sentences containing the essential point of defense which was that the prisoner's act was the direct result of an insane delusion. Lord Erskine stated that the prisoner "Imagined that he had constant intercourse with the Almighty; that this world was coming to an end, and that, like our Blessed Savior, he was to sacrifice himself for the world's salvation. He went to the theatre to perform as he imagined, that blessed sacrifice, and because he would not be guilty of suicide, though called upon by the imperious voice of heaven, he wished by the appearance of crime his life might be taken away from him by others. Hadfield had been a private in an English Dragoon regiment, had been in the wars in France and had received severe sabre wounds in the head."

King George III himself had several attacks of Manic-Depressive insanity and "The divinity which doth hedge a king" did not prevent his mind from giving way. He was immured for years within the walls of one of his own royal residences.

A case like that of Hadfield in which assassination was the direct outcome of an insane delusion, was that of McNaughton who shot and killed Mr. Edward Drummond in January, 1843. His act was committed under the impression that Mr. Drummond was Sir Robert Peel, the prime minister. McNaghton, watching Sir Robert's house and seeing Mr. Drummond come out, followed and shot him on the street. It was shown in the trial that a certain man had pointed out the house of Sir Robert Peel to McNaghton, who had then said with an oath, "Sink him." Malice and premeditation of the act was shown, but it was also conclusively shown that the act was the direct outgrowth of insane delusion, hence the prisoner was found irresponsible. McNaghton imagined he was constantly followed by spies day and night. He was a victim of what was known as "delusions of persecution" and had applied to magistrates to have

*Read before the Medical Section, State Medical Society of Wisconsin, Milwaukee, Oct. 3rd, 1918.

his imaginary persecutors prosecuted. He thought he saw men shaking fists and sticks in his face and one brandished a handful of straw signifying he should be given "A straw bed in a dungeon." The jury in this case acquitted the prisoner on the ground of insanity.

Another royal sufferer from insanity was the mad King Ludwig II of Bavaria. He was judicially found insane, dethroned and confined in one of his numerous palaces. His madness in the end brought not only himself but his physician, the lamented von Gudden, to death in the Starnbarger See. They had gone for a walk in the woods bordering the lake and as they set out, the King stipulated that the attendant who stood near by should not follow them. Dr. von Gudden, probably not wishing to offend the King, seemed to consent and they were allowed to depart unattended and were not seen again until they were both found drowned in the lake. What had occurred was never known.

In more recent times, we have seen the question of sanity and insanity fought out in the courts in the cases of Guiteau and of Csolgosz, each of whom slew a president of the United States and paid the penalty with his life upon the scaffold. Guiteau undoubtedly was insane; his brain was found diseased at autopsy, but Csolgosz apparently had a normal brain. Another case long fought over in the courts was that of Thaw whose wealth enabled him to carry on notorious legal battles in New York, Canada, Vermont and in Pennsylvania. In this connection, the mental state of some of the experts attracted attention. What are the causes of the curious state of mind generally prevailing in regard to testimony and witnesses bearing upon insanity? Often the whole community is swayed by opinions, expert and non-expert, when insanity is confidently alleged on one side and as confidently denied upon the other, in murder trials and will contests, and opinions are expressed, not only *by* experts but *of* experts? by the "man in the street." Even a judge upon the bench in making a classification of liars includes experts and gives them the highest (or the lowest) rank—not stopping to consider how *rank* is his own *pseudo* judicial pronouncement.

The reasons at the bottom of this perennial dispute (and a "hardy perennial" it is) are two:

First, insanity is in the present condition of psychopathology, generally a matter *not* of fact, but of opinion. The law deals only with facts, but one cannot say of insanity: "it is a condition not a theory"; it is *both*. In law, it is a condition, but in medicine it is a theory, a question of diagnosis; and diagnoses on difficult and obscure conditions, will differ; and differ in a perfectly honest manner. Insanity depends upon conditions of the cells, fibres and fluids in the brain which are hidden from sight and scrutiny. Opinion, as Hippocrates has told us, is "fallible," not of doctors of medicine only but of doctors of law, and opinion in the present unfortunate state of law and practice sometimes becomes a matter of bargain and sale. Finally, both of these situations grow out of a third and commanding difficulty. It is this: Insanity has never been satisfactorily defined. The law has no definition which Courts accept; first one, and then another hypothesis for each side and the contradictory hypothetical questions used by lawyers bewilder and befuddle the case. Finally, when value attaches to an opinion—when it may be a matter of life and death, it will be eagerly sought, brought from the ends of the earth, and perhaps lavishly rewarded. Now the sale of an opinion is a matter peculiar in itself. Opinions are not like commercial commodities. All depends upon whether they are true and honest, but such is the weakness of human nature and such the uncertainty as to what constitutes insanity that the aforementioned "man in the street," when he sees opposing opinions given in a court, thinks they cannot both be true; that one is *bought*. He does not see how both opinions can be honestly held, though he well knows that Republicans, Democrats and Socialists with all their contradictory opinions are perfectly honest for the most part in their differences. The determination of the point where sanity ceases and insanity begins is like determining in a rainbow exactly where yellow merges into green or green into blue and they merge so gradually that perhaps no two eyes will select the same point as the dividing line. This fact causes a deal of perfectly honest difference of opinion and misunderstanding by the public, of the attitude of the expert, not only in medicine but in all of the learned professions.

I have made my introduction unduly long and now coming again to concrete cases have only time to speak very briefly of some cases that are perhaps worthy of attention in this connection. The case of Prendergast, who slew Mayor Carter Harrison in his home in Chicago in 1893, presented

some medico-legal points worth considering. Prendergast was a poor newspaper carrier of Chicago who was born with an addled brain. He could read the headlines of the papers he sold and form opinions which he himself valued highly. One of his opinions was that he was capable of practicing law. He had read a book called "Easy Lessons in Law." He was more or less active in ward politics, and when Carter Harrison was elected mayor, as he had worked for Mr. Harrison's election, he thought himself entitled to some reward and believed he could very nicely fill the position of corporation counsel for Chicago. He called upon the mayor and presented his claim, more than once. On one occasion, when he called, he was shown the office and desk of the corporation counsel and something was said of him in jest as a likely "corporation counsel" while he seated himself in the swivel chair which was designated as his chair. The mayor treated this as a joke; no more was thought of it, but it was no joke to Prendergast, nor in the end, to the Mayor. Prendergast took himself too seriously for that. He believed he had a mission in life and that, as corporation counsel, he could reform a great municipal wrong which his feeble mind had long dwelt upon. It was the evil of the "grade crossing slaughters" in Chicago, a scandalous railroad abuse marked by almost daily destruction of life and limb the year around. Prendergast wanted to be corporation counsel so that he could remedy this shameful condition by aiding in the introduction and passage by the City Counsel of an ordinance to elevate the tracks. He felt called upon to accomplish this great reform and, when the mayor repeatedly "turned him down," he was sure a great wrong was done, not only to himself but to the community and even to the Almighty who had given him his mission. Brooding upon this great wrong, he became more and more fanatical and finally when desperate from "hope deferred," he sought the mayor out in his home and discharged the fatal bullet which instantly ended his life. That this pitiful weakling's mind was diseased there could be no question. All the most competent alienists in Chicago took this view and were retained by the defense before the prosecution had made any move in this direction. When the trial came, each in succession took the stand and testified that Prendergast was in their opinion insane, but when asked by the opposing counsel whether Prendergast knew the difference between right and wrong, they answered that he plainly did, and when asked if he premeditated the act he had done with malice aforethought replied in the affirmative. With this admission from the experts, the prosecuting attorney succeeded in convincing the jury that Prendergast was criminally responsible for his act and he was found guilty and sentenced to the gallows. A new trial was secured for him, but no amount of evidence could overcome the combination of eloquence and force in the prosecuting attorney (the celebrated A. S. Trude) combined with the hard-headed, so-called common sense of the jury who made no fine distinctions; and the general consensus of the public mind coincided in this view; yet from the medical standpoint, Prendergast was insane.

Another case, locally familiar, in which the issue of insanity was tried out and met in a more satisfactory way was that of John Schrank who, as many of my hearers will recall, in October, 1912, attempted the life of Theodore Roosevelt in Milwaukee. The would-be assassin was a young man of German extraction who had been a saloon keeper in New York formerly, but had given up this vocation and of late had been seeking an opportunity to attempt the life of Colonel Roosevelt in various parts of the country.

When the case came on for trial before Judge A. C. Backus, the Judge utilized a provision of the law whereby, before the trial for his act, the question of sanity or insanity could be determined. A commission of five Milwaukee alienists was appointed and this commission was charged with the duty of determining the question of sanity and was instructed there was nothing for them to consider except the mental state: whether the prisoner was at the *present* time sane or insane. If the prisoner should be found sane, he would then be tried for his act. If, on the other hand, he was of unsound mind, he would then be committed to the criminal asylum as being unable to properly frame or understand his own defense.

Inquiry into the state of mind of this man showed that he believed himself to be a reformer and a hero. He had been inspired by dreams and visions. He believed that as "Joan of Arc," the Maid of Orleans was inspired by the Holy Virgin, so it had been revealed to him in a dream that he was to be the Saviour of the country. He believed Col. Roosevelt was guilty of McKinley's assassina-

tion (this had been revealed to him in a dream), and he, Schrank, was to avenge this act. He also had a theory that the government of the United States rested upon a foundation which he called "The Four Pillars of Our Republic," namely, (1) the Third Term Tradition, (2) the Monroe Doctrine, (3) that only a Protestant by creed can become president, (4) no wars of conquest. These "four unwritten laws" had assumed in his mind a character of sacredness. They were "sacred traditions" to be maintained at all hazards, particularly the tradition of no Third Term.

An interesting case in which the question of the validity of a will was the point at issue was that of Stratton, of Colorado, the discoverer and owner of the Independence Mine which he sold for several millions to an English syndicate. This man left an estate of more than ten million dollars to the "people of Colorado" to be used for the benefit and welfare of the poor. His life had been that of the ordinary miner. He had many years before coming to Colorado been married, but had held no communication with his wife or with a son, the issue of this marriage for many years. A contest was begun by the son, but was finally compromised for less than one hundred thousand dollars. The contestant probably became satisfied the court would sustain the will. The position generally taken by courts is that if a man is shown to know and understand the extent of his property and has reasonable grounds for disposing of it as set forth in the will, that even very great eccentricities, even delusional ideas if having no bearing upon the will should not be allowed to vitiate it. Wills have often been sustained by the courts that were made by people known to have been mentally deranged and even a will actually made in an insane asylum to which the testator had been legally committed was upheld as being in itself a reasonable document in one of the English courts.

Uncle Sam will provide sanatorium and hospital care for all the boys discharged from army or naval service, so far as their sickness or disability was contracted in the service of their country. The United States Public Health Service has already undertaken this stupendous task and is busily engaged in enlarging its hospital facilities all over the country. One of the sanatoria will be located at Dawson Springs, a famous health resort in Kentucky; the location of the others has not yet been determined.

TUBERCULOSIS—A MEDICAL SPECIALTY THROUGH POPULAR DEMAND.

BY GEORGE THOMAS PALMER, M. D.,

PRESIDENT OF THE ILLINOIS TUBERCULOSIS ASSOCIATION; ASSISTANT DIRECTOR OF THE STATE DEPARTMENT OF PUBLIC HEALTH,

SPRINGFIELD, ILL.

Internists and general practitioners have been very reluctant in the past to accord to tuberculosis the dignity of recognition as a medical specialty. One of the war horses of medical education, when it was suggested that the medical college with which he was connected create a chair of tuberculosis, made a show of great disdain and replied: "Next it will be urged that we establish an endowed chair on piles." And so his medical college continued, as it had in the past, and as many other medical colleges still continue to do, to devote little attention to tuberculosis in general and even less to the early diagnosis of pulmonary tuberculosis, upon which all successful management and treatment of the disease depends.

It is quite unnecessary, at this time, to dwell upon the general neglect of this vitally important subject in the past or to comment upon the very hazy idea of the disease possessed by the average physician when he sets forth in the practice of his profession. Nor is it profitable to dwell upon the lack of interest usually manifested by the general practitioner as, year after year, he has met the never ending procession of consumptives in his professional work. Nor, incidentally, is it necessary, in these pages, to remark upon the skill and painstaking care essential to the diagnosis of tuberculosis in its earlier stages.

Of my recollections of my own medical school days, I can recall rare nervous afflictions which I have never seen in the twenty years which have elapsed since that time and strange skin diseases which I have never encountered or which I have never been able to recognize, and yet I do not recall any special stress being laid upon tuberculosis or any instruction on the diagnosis of the disease in its early and curable stages. The description of phthisis given me at that time, as I recall it, was the terminal chapter of the story which might have proven valuable as the preface to autopsy notes.

At any rate, I clearly recall that I left medical

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school with the impression, gained from my course of instruction, that, from the standpoint of the physician, either typhoid fever or appendicitis was more important than pulmonary tuberculosis.

With so slight attention accorded to a disease which causes one-eighth of all human deaths and, perhaps, directly or indirectly, one-eighth of all human illness, it is hardly to be expected that it would be dignified by any special recognition in the course of but two decades unless there had come about an actual revolution of thought.

There has come a revolution of conception in regard to tuberculosis—a radical change in attitude—through which the diagnosis, treatment and management of the disease have come to constitute in fact a distinct specialty and that change in conception and attitude constitutes one of the most remarkable and interesting chapters in the history of modern medicine.

A medical specialty, as I understand it, is a branch of medicine requiring exclusive application on the part of the practitioner to permit him to develop the high degree of technical skill essential to his successfully engaging in it. Measured by this definition, tuberculosis is essentially a specialty since, regardless of the details of diagnosis and treatment, whose mastery is rare enough at best, its successful practice involves a combination of medicine, social viewpoint, psychic influence and individual management found nowhere else in medicine, unless it may be in the public side of pediatrics or in the treatment of mental diseases.

A more practical, if not commercial, definition of a specialty is a field of medicine in which the demand is so general as to warrant or require the full-time service of considerable numbers of physicians to meet the public need. Measured by this definition, tuberculosis stands out throughout the entire Nation, and particularly in Illinois, as a specialty of the first magnitude.

Within the past two years forty-one Illinois counties have voted on the proposition of establishing tuberculosis sanatoria, free to rich and poor alike, together with tuberculosis dispensaries and visiting nurse service for the tuberculous, and the sentiment of the lay population is made clear by the fact that forty of these forty-one counties adopted the measure by overwhelming majorities. Thirty-three of these counties submitted the proposition at the autumn election of 1918 and of these all declared their approval of establishing sanatoria, in some communities by a vote of six to one.

And now these counties, which have taxed themselves hundreds of thousands of dollars to establish the machinery to meet their gravest medical problem, are confronted by the fact that a sufficient number of physicians, proficient in the diagnosis and treatment of tuberculosis, is not available for these sanatoria and dispensaries. The situation is quite as unusual and perplexing as though forty hospitals for major surgery had been suddenly created in a state of wide area in which barely a handful of physicians made any pretense of practicing surgery or manifested any genuine interest in it. We recall the oft-repeated assertion of the late Theodore B. Sachs: "It is far easier to raise money and to build tuberculosis sanatoria than it is to secure physicians capable of conducting them."

With the present tremendous popular interest in tuberculosis, it is not at all unlikely that the remaining sixty counties of Illinois will put the sanatorium proposition before the people two years hence and, if so, it will probably carry in every county. In that event, over one hundred Illinois counties will require the services of physicians proficient in the diagnosis and treatment of tuberculosis.

And this brings us to consider the peculiar development of tuberculosis as a medical specialty.

As a rule, medical specialties are developed within the medical profession, and the services of these specialties are offered to the public, by which they are accepted, at times, with a certain degree of reluctance. The physician who desires to practice a specialty often finds that he must knock lustily at the door and must pass through many lean years, regardless of his fitness or ability. The attainment of admission to or recognition by some of the more exclusive special medical societies constitutes a difficulty, if not a barrier, to many ambitious young men.

Interest in tuberculosis, on the other hand, has developed largely outside of the medical profession, guided, of course, by a comparatively small group of medical men to whom we are indebted for the advancement of the scientific side of the subject to a point that is more than creditable. The general public have continued to agitate the tuberculosis problem until they have provided remarkable medical machinery for which they are asking the medical profession for expert guiding hands.

The people have awakened to the fact that tuberculosis is not an inevitable scourge. They have become aroused from the lethargy in which they accepted this preventable and curable disease as a matter of course. They have been taught, by their own tragic experiences, that the successful handling of tuberculosis requires something more than they have been receiving from the medical profession in the past. They believe that the requisites are greater knowledge, greater skill or, at any rate, greater interest on the part of the doctor and, in so believing, the public have created a medical specialty ready and waiting for the medical profession to man when the medical profession is prepared to do it.

It is not a specialty full of golden promise. It is one in which the physician of commercial tendency, or without social outlook, is likely to fail. It offers only moderate monetary recompense. It offers, however, an opportunity for distinct public service in a specialty uncrowded and in a field so neglected in the past that it is pregnant with possibilities for scientific development.

The popular interest in tuberculosis has caused to be placed upon the gate-post of every large county or populous community a sign which reads: "Wanted! A Man!"—which marks a splendid field for the highest type of professional skill if coupled with the cleanest type of social conscience.

It is rather unique, in the present over-crowded condition of general medicine, to find a specialty ready-made and waiting for workers. It is also unique in the annals of medicine to find a field of special medical activity so wide and so definitely prepared that those already engaged in it are urging others to join them in their tremendous undertaking.

The United States Public Health Service submits the following list of "our animal friends" and wonders what we propose doing about it:

Anopheles mosquitoes, which carry malaria.

Aedes mosquitoes, which carry yellow fever.

Lice (with military training), which carry trench fever.

Lice (with or without military training) which carry typhus fever.

Flies, which carry typhoid fever, dysentery and other diseases.

Fleas, which carry bubonic plague.

Tsetse flies, which carry African sleeping sickness.

Hookworm, which is very much attached to man.

THE PSYCHOLOGY OF REFRACTION.*

BY M. P. ANDREWS, M. D.,

BELOIT.

Some modern philosopher has told us that success depends not so much upon never making a mistake as on the ability to keep from making the same mistake a second time.

When we review our own failures in refraction —such of them as come to our attention, for most of them go to the other fellow—and when we analyze the failures of others who come to us, we cannot help noticing that failure to give satisfaction does not always depend upon the amount of the sphere or cylinder prescribed, but is, in many instances due to psychological reasons affecting the understanding and relationship between the patient and his refractionist.

"Successful refraction" is a broad term and stretches from the time the patient decides the question of whom to consult, until he or his oculist dies or leaves town. It means much more than mechanical correction of defective vision with glasses, it means a conscientious certainty of his work in the doctor and an inspiration of complete confidence in the patient, with such an impression of the thoroughness and the carefulness of the work being done for him, that he will respond with the same sort of effort on his part, both during the examination and after he has gone from the office, and will come back where he should, to report his troubles, if there be any. In such a state of harmony between the opthalmologist and his subject, the four main elements of sucess will be: *truthfulness, co-operation, confidence, and satisfaction.*

Let us now consider some of the mental attributes and conditions which may interfere with the bringing about of such a desirable relationship.

Before discussing the patient, it may be well to say a few words about the doctor, for he is as human as his subject and often much more sorely tried. Much depends upon his personality. He may be strong in this respect; if so, he will need to be careful lest his strength be arbitrary and dogmatic and he become an object of fear to the child and of dislike to those who are timid. His strength must be pliant and his poise many-sided.

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*Read before the Eye, Ear, Nose and Throat Section, State Medical Society of Wisconsin, Milwaukee, October 3, 1918.

He must avoid seeming to be absent-minded, irritable, hurried, undecided, impatient; he must seem to be open to conviction, and to be interested in the unusual importance of the symptoms under consideration. Ophthalmologists have the reputation of being cranks. This, of course, is entirely undeserved. The doctor should be able to hold his own emotions in abeyance and in so doing, set a proper pace for the patient. Fear, dislike, excitement, anger, anxiety, great joy, or enthusiasm may interfere completely with the process of a refraction, and lead to an unexpected state of mind afterward. Refractions are much better postponed when such conditions prevail.

It is seldom wise to attempt to refract very young children until they feel comfortable and natural in the office, although it may require several visits to bring this about. Pennies, chewing gum or other things for the mouth are much better than things that go into the eyes at this stage. Let the mother use the atropine at home.

Very early in an interview a dislike may spring up. It may be a natural antipathy such as may be sensed almost immediately when two people predisposed come into each other's presence, or it may spring up spontaneously in a patient if the doctor succeed poorly in camouflaging his first impressions.

Few people ever do things in anger, things they become proud of; it is as disastrous in a refraction as it is in a golf match. A mother who has brought with her to the office, a small child whom she must frequently pacify, is a very discouraging case to work upon. Some patients have a very uncontrollable, unsystematic verbosity which interferes hopelessly with their own power to concentrate, and the doctor's power to keep the reins in hand.

These transitory states due to the play of emotions can usually be overcome by tact and plans of procedure fitted according to the need. There are other conditions more chronic, which require more genius to circumvent, of such we might mention: established prejudices, pet theories, the various delinquencies and irresponsibilities of those mentally, morally, and economically below par; nervous idiosyncrasies, difficulties due to functional and organic disease, and due to age, sex, and occupation.

Of prejudices and pet theories there are many, very few people come to us entirely free from them, and although it may be necessary to anticipate, run down, and correct them, we must remember that the average person does not enjoy having a pet idea trodden down ruthlessly, but prefers to see it put to sleep with gentle touch and sympathetic benediction.

These prejudices and theories most frequently have to do with: the use of mydriatics, presbyopia, putting of glasses on children, the prices of glasses, the notion that to once submit to the wearing of glasses means the acquiring of a habit to be avoided, and fantastic notions about the sizes of lenses and types of mountings. Have we ever seen a person with a 45 millimeter pupillary distance who did not insist on having a 46 millimeter lense; or a nose of a luetic or ethiopian type that anything but a Shur-on would pacify?

The thrifty ten cent store addict usually has some very pointed opinions regarding the various species of robbers, and drops a word or two when he pays for his wife's krpytoks.

Vicious ideas concerning the use of mydriatics usually are announced before the patient condescends to be seated; and generally signifies that the patient be rather ignorant, a Christian Scientist, follower of some quack healing system, or has been frightened by some brother-in-law optometerist. Occasionally some tired business man who takes three minutes for meals and three hours for his P. G. at the club, objects because of losing a little time. The most trying people to please are perhaps the newly presbyopic. They do not want bifocals, will not have two pair of glasses, and cite you most glibly to Mrs. So and So, five years older, who got her glasses of Dr. Competitor and can wear them for everything.

Mr. Grouch will come in on Saturday night to pay for his child's glasses which measures minus 4 or plus 6; the need of which the school physician has discovered; he will tell about his grandfather who lived to be over 90 and never had a pair of glasses, will call glasses a humbug and if you agree with him may wind up by getting a pair of reading glasses for himself.

One must watch out for the veracity of the person who tells how much better or worse he can see through an empty trial frame. The peculiar whims relative to the size, styles, and methods of wearing glasses, and the character portraying peeves that grow up as a result of these petty difficulties would require the wizard skill of O'Henry or the patience of a Dickens to describe.

The delinquencies and irresponsibilities of our patients are perhaps the most formidable and unmanageable of the conditions we have to meet; these apply not so much at the time of the refraction, as later. In many instances one must go ahead and do his duty, knowing full well that the end result cannot be anything but failure. Such short-comings may be classified as follows:

Due to Race. The negro and the Italian are the least dependable in carrying out instructions or following advice.

Due to Age. The small children of irresponsible parents, the spinster with beginning presbyopia and inordinate pride, and the childish old person; all do as they like when out of sight.

Due to Social Status. Conditions of life, of course, play an important role. The dependability will be governed more by the degree of education than by the financial condition. Well-to-do people who have received notice from the school examiner, of defects of vision of their children are frequently indignant and unreasonable, but let a child be delinquent in his studies and the fond mother in grasping for a straw will grab even a pair of glasses if exoneration goes with them.

Due to Instability of Purpose and Opinion. Such people we have in all classes. They change oculists just as often as they change politics, religions, and jobs.

Due to Money Matters. There is nothing quite so inevitable as the contempt of a person for a pair of glasses he has had a couple of years and for which he is just being forced to pay. Glasses paid for in advance by such people are singularly efficient and monotonously extolled.

There is a long list of nervous idiosyncrasies, any of which is capable of interfering with a satisfactory result. An adjustment of the frame or mounting that would be perfectly satisfactory to the average person may be absolutely intolerable to some one. One person cannot accustom himself to the light reflection on a toric lense, another will not wear a flat lense. Often there will be a complaint of seeing some part of the frame. Sometimes a slight pressure on the nose or ears will so distract a patient that they become miserable. Some people can give no reason except that they feel harnessed up with glasses on and do not rest easy until they get them off again.

A sometimes serious and baffling thing is the disturbed orientation of a person past middle age when he first puts on cylinder lenses, especially so, if the axis of the cylinder be a diagonal one. I have found that by predicting to them, just the way floors, doors, stairs, and telephone poles are going to re-arrange themselves, that they are much more easily pacified.

The experiences of the people beginning to wear bi-focals, who are anxious to get away with it, are bad enough; but the "come-back" of the old maid who took them under protest no doubt had much to do with the opthalmologist's reputation of being an old crank.

People suffering with various chronic diseases such as diabetes, Bright's disease, cataract, glaucoma, and beginning optic atrophy, where the vision is changing, are given to making collections of glasses. Such futile expenditure from the frequently slender bank account adds pathos to an already sad story of unrealized hopes.

A series of deaf people in for refraction on a busy day is a sure forerunner of a vacation. A good ear trumpet is a gratifying accessory to a refractionist's equipment.

The age, the sex, or the occupation may have a bearing on the various difficulties of our work. These things have to do not only with the psychic pecularities of people, but many times require a modification in our treatment. An optholomogist should make it his business to know about the environments and employment conditions of his people. Glasses must be fitted not only to the patient's eyes, but to his mind, his temperament, his habits, his age, his environment and occupation.

In connection with the subject of the ability to concentrate attention for the refraction process, and of adequate co-operation to follow, there are a few types worthy of special mention, and they may be mentioned together for they occupy common ground, and that ground is now hallowed ground. The person with hypochondria, the one with hysteria, the unwilling spoiled child, the deceptive child who wants glasses because her playmate wears them, the chronic joy-killer, and the semi-intoxicated. This ground is treacherous ground to walk upon. We will not linger near it, even in this paper.

The various phases of this subject which I have today barely called to your attention are innumerable and endless, and in the busy pursuit of more sensational and scientific knowledge, may seem of

small importance. Many of us in our hasty stride move too swiftly past the little things of life, and neglect establishing the relationships with our fellow-beings, so essential to success. If any one can be a bit of a philosopher and can keep interested in the endless study of other human types, and can at the same time keep in touch with his own inclinations, attitudes, and attributes, he cannot help acquiring a better mental poise for the trying situations ahead. Refraction will not be an endless drudgery; and although such effort will not be without substantial reward, a greater reward will be found in the pleasure of achievement.

DISCUSSION.

Dr. Chapman: I do not believe I ever heard a paper or read a paper which showed so much labor and effort in getting together the trials of the refractionist and dealing with them so philosophically. I believe there is not one of us but can fully appreciate it. I want to thank Dr. Andrews very much for gathering this together in this form and presenting it as clearly as he has. I think it is one of the most interesting papers of the whole meeting. Certainly it is food for thought for all of us.

Dr. Trowbridge: To those of us who operate for cataracts occasionally, this is one of the best papers we have heard. It is one that strikes home to every one who practices opthalmology. When a case of incipient cataract comes to me, I always say, "I do not expect to satisfy you—that is, as you would like to have me. I do not expect to put a glass before your eyes that you will see with very well; if we are lucky enough to get 20/40 with glass, you should feel well about it," but we make it very strong to them that in about six months or a year they will have to come back again and be refracted over, and I find, as Dr. Andrews has said, it is a very good way to make it very plain to them that it will not be as satisfactory as they had hoped. I enjoyed the paper very much.

Dr. Higgins: Quite frequently our well intended explanations regarding the heavy lenses necessary after cataract operations are not fully comprehended by those good patients whose case is associated with mild senile mentality. Recently one of the old soldiers at the Milwaukee Soldiers' Home refused to pay for his glasses because he could still see with the unoperated eye.

Dr. Andrews: One of our members here present requests me to ask the experiences of any of our members in the use of sub-conjunctival injections of cyanide of mercury in incipient cataract.

To show what foolish refractions may sometimes be amiably accepted by the public. I would like to tell of a case that comes to my mind: A lady of about 55 years of age, after being refracted and advised to have either two pairs of glasses or a pair of bifocal lenses, stubbornly insisted, that she had previously been satisfactorily accommodated to both distant and near vision by a single pair of lenses, and proudly displayed them. In looking into the matter I found her wearing a plus I on one eye and a plus 3 on the other, and her eyes were alike. She had been using one eye for the distance and the other for reading and sewing and had never discovered it. After explaining to her, she readily transferred her affections and followed my advice.

Chairman: The best pair of eyes I ever saw belonged to a reverend gentleman who had external strabismus. The right one was myopic and the left eye was hyperopic, and when he wanted to see at a distance he used one eye, and when he wanted to read, he used the other.

Clinical Microscopy and Chemistry. By F. A. McJunkin, M. D., Professor of Pathology in the Marquette University School of Medicine; formerly an assistant in the Pathological Laboratory of the Boston City Hospital. Octavo volume of 470 pages with 131 illustrations. Philadephia and London; W. B. Saunders Company, 1919. Cloth, $3.50.

A Wisconsin man in whom our readers are interested has written what we predict will be a most successful laboratory manual. It is a work which will prove most practical and helpful to the physician in his every day practice of medicine. The subject is presented from the laboratory point of view and special emphasis has been given chemical, bacteriological, serologic, and pathologic methods.

The lengthy clinical descriptions which are accessible in text books on clinical medicine have been avoided. Only those methods have been included which have a definite and practical use, and the work is not burdened with a long tabulation of a great number of technical procedures. It is complete, however, and covers the entire field of medical laboratory work. The illustrations, many of them in color, are excellent and the work can be recommended to the student, the busy practitioner, and the laboratory worker.

The Disabled Soldier. By Douglas McMurtrie, director of the Red Cross Institute for Crippled and Disabled men; president of the Federation of Associations for Cripples; editor of the American Journal of care for Cripples. With an introduction by Jeremiah Milbank, vice-chairman of the Committee of Direction, Red Cross Institute for Crippled and Disabled men. The MacMillan Company, New York. 1919. 232 pages. Illustrated. Price, $2.00.

This little work, dedicated "To the American soldiers gone out to France to risk physical disablement in the cause of freedom and right," is most interesting both to the professional and lay reader.

It advocates in popular form the logic of the arguments in favor of rehabilitation for self support and it will help to make clear the subject and secure for this work a cordial and hearty acceptance. It is written in an interesting readable style and once begun is sure to be finished within a few days. It is attractively bound and beautifully illustrated with twenty-five full page halftones. A splendid work for your reception room table when you have finished it yourself.

REPORT OF A CASE OF SARCOMA OF THE NOSE.*

BY SAMUEL G. HIGGINS, M. D.,

MILWAUKEE.

The case I have to report today, apparently when first presented to a doctor, showed nasal obstruction and what looked like nasal polyps. Although the little boy was then only five years old, the polyps, so the sister said, were removed in May by a doctor in her home town, by whom I do not know. The growth recurred and on August 10th the parents consulted others and the child referred to me. At this time the child was a constant mouth breather. His expression was other than that of a mouth breather in that beside the drooped facial lines and the open mouth the teeth were not irregular, the tonsils not enlarged and the dental arch was not particularly heightened. The external nose was broad especially through the bridge and mid nasal region with a swollen wide face, more especially of the right cheek. Examination within the nares showed the left side closed by the total deviation of the septum to the left. The right side was completely obstructed by what looked like firm though shining polypi. These appeared to be of from one mass, watery gray surface but on a hard dark red background. Very little manipulation was possible as the space barely permitted one to wipe off the thick mucus and mucopurulent stagnant smelling discharge. A snare of this tissue was reported from the laboratory to be sarcomatous. X-rays of the face showed the entire sinus area of the right side including the antrum deeply dull and the left nasal space dark but with some lighter area at the outer limits of the left antrum. The only hopes of removing the growth was thought to be by out flanking the entire mass and removing the limiting membranes of the sinuses and all cavities envolved.

With this thought in mind the child was operated on August 17th under ether narcosis; the incision was made along the lower border of the right orbit from a point near the center of the orbit extending near the upper curve of the nose, then down the line at the border of the cheek and nose around the curve of the external nares down and up into the right nares. The cut severed all tissue to the bone with the flap including the periostum. The anterior face of the right antrum was chiseled open with the bony wall removed extending to the floor of the nose and limits of the orbit above. The bony wall removed was similar to that in the Denker operation including the anterior wall of the antrum and portion of frontal process of the maxillary bone but none of the nasal bone was removed. The growth was found to be of firm consistency, dark red in color with a glistening surface and filled the antrum completely, in fact, pushing the walls in all directions. The most marked crowding effect was on the septum which had been laterally crowded into the left nasal chamber. The Belocq's canula, or rather copper wire, that carried the gauze sponge packing of the posterior nares was forced through the right nose, space not permitting in the left side. This crowding over of the septum accounted for the X-ray shadow of the left cheek and antrum. When the anterior wall of the antrum was removed the membranes lining the antrum were separated from the bony wall, this movement continuing along the orbital wall and into the nasal fossa over the roof of the nose, also along the lower floor including the floor of the nose so that all of the ethmoidal labyrinth, upper turbinal bones and the inferior turbinate were removed with the growth in mass. The tissue at the roof of the nose was cut off by flat biting nasal forceps while at the floor of the nose the membrane was cut near the septum with a firm long handled nasal knife. The growth had not denuded nor become a part of the septum wall. Plain gauze soaked in acetozone inhalant was packed in the entire area with drainage through the nose. The posterior gauze plug prevented any blood entering the posterior nares and throat. In fact there was very little bleeding, not as much in fact as when the snare had been used to remove a portion of the polypoid appearing growth before. After having placed the gauze in the wound and closing the entire skin incision with interrupted sutures the post nasal gauze was removed and by palpation a fair sized amount of distinct soft adenoid tissue was felt. For once adenoids were not removed! The post operative recovery may be said to have been uneventful.

Acetozone dipped gauze, which I find very useful in nasal surgery, was removed without much complaint. A portion of the gauze was removed on

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the second and third day after the operation when a liberal amount of 5 per cent calomel ointment was placed in the nose and more ointment when all the gauze came out on the fourth day after the operation. No watery irrigating was done. The septum side of the wound was protected with gutta percha. The wound was left dry for two days after which the intra nasal space was irrigated once a day with 95 per cent alcohol with the soft rubber bulb aural syringe. The head was held far forward and a small amount used the first time. All the stitches and all the gauze was out within a week. Deep X-ray therapy administered three times during the ten days he remained in the hospital when he returned to his home out of the city.

This case conforms to the literature on the subject in most respects. As to incidence sarcoma is uncommon, primary carcinoma of the nasal cavity is rare. An exhaustive study of sarcoma of the nose by J. A. Watson found 150 cases reported in as many years.

The more frequent age is in adults between 40 and 50 though a case in a child of two years is reported. As with the more frequently encountered fibroma of the nose, males are more often the subject of the growth than females. Any of the varieties of sarcoma may be met with in the nasal fossae. The investigations of J. A. Watson show that (small) round-celled sarcoma is the most common; fibro-sarcoma comes next in order of frequency; myxo-sarcoma occurs about half as often as fibro-sarcoma. Then, in decreasing order, come spindle-celled sarcoma, melanotic sarcoma, angio-sarcoma, and adeno-sarcoma. Osteo-sarcoma, myeloid, alveolar, and lympho-sarcoma have also been reported.

Writers on the subject agree that pathological idenities very, though the existence of a presarcomatous state is not proven. There are however progressive stages of malignancy of sarcomatous intranasal tumors and of intranasal tumors clinically diagnosed.

From the history of this case with a comparatively slow growth it may occur to us that there was a stage in which the growth was not malignant at least at which time the prognosis would have been better than when the boy was finally operated. The myxomatous tissue in this case was probably true nasal polypus from hyperplasia of the mucus membrane. It is possible that neglected polyp tissue with nasal infection and discharge may be the inflammatory condition that excites the sarcomatous growth in the deep connective tissue in the nose. The exciting cause is said by writers to be either trauma or inflammation. The site may be from the sinuses and *if* sinuses the antrum is the more usual place, though the ethmoidal labyrinth or sphenoid are also primarily envolved.

Sarcoma may arise from the floor of the nose anteriorly or even the septum though in this case the septum was not involved. The usual pathology of these cases teaches us that thorough eradication offers some hope of cure. That is the nasal sarcoma are usually of slow growth and of the large celled variety. Also the diagnosis is apt to be clinically confused with fibroma and the sarcomatous growth itself present with myxomata or mucus polyps. Whether there is a benign stage or not the possibility of help by operation is not to be excluded. The pathological report on the whole mass which was carefully studied by Dr. Daniel Hopkinson gives us a picture which supports our first clinical view of this case, that of the last stages of malignancy. The typical text book photograph in Delafield and Prudden's Pathology of a psammatous endothelioma of the dura is reproduced here and may be studied by you under the microscope from the accompanying slide. This picture is of endothelial aggregations or whorls and with spindle cells and with hyaline degeneration in the stroma. Clinically the mass in the antrum suggested that sinus as the origin.

Whether the primary site was there or not I cannot say but we must admit from the pathological report that an endothelial tumor was present of the type that originates from the dura and in this case it is probable that the dural tissue was that that evaginates into the ethmoidal cells.

As to treatment we are presented with the problem of reconciling the conflicting pathological report with Kyle's statement that the prognosis of sacroma is better when occurring intranasally than in any other portion of the body. Moreover I cannot accept his recommendation of galvano cautery or the current for eradication of such a growth. My experience with malignant tumors as not infrequently met among the members of the (old) Soldiers' Home here in Milwaukee is such that all malignant growths should be removed in mass and with as much adjacent supposed normal tissue as the locality will permit. Slicing, curetting, snaring and burning are not a part of the

surgery of malignancy in the attempt to eradicate the disease. This idea will bear repetition especially as we are apt to try these measures early in the disease, at the very time when some real eradication can be accomplished by thorough radical operation.

DISCUSSION.

DR. C. G. DWIGHT, Madison: I want to ask how long he used the X-ray? How long was that followed after the operation?

DR. HIGGINS: I think he has had a few treatments since, but I have not had the child directly under my care, and was not able to get a report except through the children. I don't know who, if any one, is responsible for the case now.

DR. DWIGHT: When was the operation?

DR. HIGGINS: August 17th, this year. The child is here this morning. You may inspect the wound now.

DR. DWIGHT: They are very difficult cases. There was one fell into our hands, and the X-ray has seemed to be the way to handle it, following operative work. In my own experience I have been unable to control those cases without violet ray following. I had a case substantially the same as Dr. Higgins, which came into my hands less than a year ago, and I refused to operate. The case ended up finally in Chicago, and was operated and there burried. I never saw such a large growth following surgery. It was so big it could not be removed. Both Luminea of the nose was completely packed full. The ethmoid region back to the sphenoid was one mass. The case was operated and had continued to grow, and the man died in less than three months. I would not touch it. There is a time in these cases where it is inoperative.

DR. ANDREWS: I want to tell of a case which will show the sometimes absolute futility of any and all treatment:

A girl of twelve years of age, child of careful, intelligent, well-to-do parents, was discovered to have a small nodule on the forearm. It was removed surgically at once, and examined pathologically. The report being "Sarcoma," originating in nerve tissue.

The arm was promptly removed well up into the shoulder. The child recovered nicely, went south for the winter and for a short time gained in weight and condition, but in the spring began to fail, and a mass appeared at the upper end of the sternum. Being inoperable, X-ray treatment was recommended, and a very complete outfit was installed in the home, and the most competent man available was secured to come out from Chicago to give the treatments. The mass disappeared, after which the patient developed choked disc, a divergence, and a partial paralysis of hearing and of speech, and went gradually to a pitiful end. The questions in my mind are: Was the nodule on the arm the primary lesion? And, did the reduction of the mass on the sternum by the X-ray hasten the development of metasteses in the brain?

DR. PFISTER: I have had two cases of sarcoma in the last two years, and I regret that I cannot have them come here to the meeting. They were cases, one in a man about 36 years old, and the other in a young man about 20. The first cast came to me for bleeding from the septum. On the anterior part about the middle to away up he had a spongy-appearing growth, with not very much bleeding. I thought the thing looked suspicious, and I took off all the whole soft covering of the septum within a radius of an inch of that area. I think Dr. Hopkinson will remember the case and the microscopic finding. In about three months he came back. The thing was bleeding again, a little farther up and back. I was not going to take any chance, and I took the whole septum away, leaving nothing but just the small piece in the front, and going back as far as the naso-pharynx. It was surprising and interesting to me to see no change in the voice, and no deformity in the bridge of the nose. He got along for about four months. I then sent him to a local gentleman here for X-ray treatments and also radium, but about four months afterwards the thing started out in the ethmoid region, and I cleaned out that region thoroughly, making a hole I could stick half my fist in. Everything looked spongy. But, to make a long story short, this man went from bad to worse. The spongy part had to come out, and the bleeding was very frequent and serious, and those treatments with the X-ray and radium did not do any good. So I sent him to Dr. New, Rochester, whom I had seen do some good work, to see what he could do about it. It was only a short time until the man died. Everything was involved, sinuses, frontal sinuses, the eyes began to protrude, and he finally died.

Another case was of a young man 20 years old. He came with a history of nose bleeding. On examination I found a bleeding space posterially in the nose, which looked spongy. I took that off, and Dr. Hopkinson will be kind enough to verify the report that it was sarcoma. I took out the whole inferior turbinate. This case also went to Rochester and came back, and he died a miserable death. I think some of the gentlemen here might have seen the man at the Mt. Sinai hospital.

DR. DANIEL HOPKINSON, Milwaukee: I think from a pathological point of view, the case reported by Dr. Higgins is very interesting, especially as to its origin, and this origin I did not believe could have been thought of without microscopic examination. Microscopic examination showed the presence of structures in the form of endothelial whirls. At the time I made this microscopic examination I didn't know exactly the location from which this tumor had been removed, but after having made this, it was not difficult to suppose, and probably correctly so, that this tumor originated in the dural covering of the ethmoidal space, and further permeated the nasal cavity. Probably also as these tumors are, it was originally a simple fibro-endothelioma, non-malignant in type, and later, as shown by the spindle cell development, became transformed into sarcoma. There is one thing we should all be impressed with, and that is the fact, very frequently the myxomatous tissue of the nose can-

not be gaged so readily as to its malignant tendency. This tissue is present to a large extent in other situations. When a myxoma takes place, we immediately suspect a reversion to the embryolitic type, and very probably transformation into malignancy. If we examine tumors in some polypi, we see a lot of that tissue and really—infrequently a transformation into sarcoma. Also we often see an invasion, a round cell proliferation, which makes it difficult to distinguish. Sometimes we call it sarcoma when it is simply an infectious process upon a myxomatous polypi.

Regarding the case referred to by Dr. Andrews, myxomatous sarcoma is entirely different from carcinoma. It would not be the rule to expect to locate metastasis except in the thoracic cavity at its earliest stage. Metastasis takes place in myxosarcomas through the blood vessels, whereas in carcinoma it is sometimes possible to control the local or regional invasion in that it travels through the lymphatics, and may be detected in these situations early, but I do not believe that there is more difficulty in determining malignancy in these polypi than in any other portion of the body.

The cases referred to by Dr. Pfister, the first one was a myxosarcoma, and the second one was a round sarcoma.

Dr. Allen asks in regard to giant-cell sarcoma. Most of them I think are found in nasoantrum, the nasal cavity, originating within the throat, and then they invade the nasal cavity.

Dr. L. P. Allen, Oshkosh: What effect does that have? Are they related to the others?

Dr. Hopkinson, Oshkosh: No.

Dr. Higgins: I did not go into all the symptoms and differential diagnosis on the case reported. I thought there would be enough discussion to bring that out pathologically. The literature speaks of the large-cell sarcoma, associated with slow growth, and originating more frequently from the septum or anteriorly rather than on the floor of the nose or in the antrum. So that we have today a very unusual case. There is mention, more especially, in books of five and ten years ago, with regard to benign tumors. I remember the general surgeons talking about a pre-carcinomatous stage, and I often wonder if that could be the case in the nose, where we have the benign mucous growths, and whether they could change over into the malignant tumors. It would seem to me more that they are the exciting cause by causing a laceration and continued retention of the normal mucous, and that going on until you have an inflammation which would excite the growth of a new tissue, of a malignant character. As we all know, sarcoma spreads through the blood vessels, while the cancer growths follow the lymphatic, and that, of course, is important clinically, because it is only very late in the nasal sarcomas that we find any enlargement of the glands, and probably the enlargement of the glands and tributary glands is due to infection rather than a growth of the tumor itself. Of course metatesis of the blood vessels would give a growth in any place, and, as reported by Dr. Andrews, probably those metateses are a part of the disease rather than the primary location where the disease was first discovered. Under this head of symptoms, with large glands, etc., it is peculiar that there is not more pain, and that is important because these people come in with polypi and nasal obstructions, and we do not think much of it. There is bad odor and ulceration, but if they do not come back, we art apt to wait as the patient does. It is still to be hoped that we can make a diagnosis early and thereby gain most through the full radical operation. As far as the treatment goes, besides surgery, I have not found any result from radium. I guess radium has been more a less abandoned. The X-ray, I believe, should be continued, and of course, when you are dealing with a structure which involves such a large area, the form of treatment is different than it would be for epithelioma or superficial growth. The tube used here is the hard tube for deep treatment. This specimen is here; if any one wants to look at it they may do so at their leisure.

TRACHOMA.*

BY CORYDON G. DWIGHT, M. D., F. A. C. S.,

MADISON.

From time immemorial Trachoma has existed in Europe as an endemic disease. It is then an old story I am endeavoring to tell you about. I have nothing really new to offer as a successful curative campaign, but wish more to make as clear as I possibly can the diagnosis of Trachoma.

Trachoma was mentioned in the Ebers Papyrus, and its treatment was described by Galen, who was born A. D. 131 and died A. D. 210. It is within the last century that Trachoma has attracted the attention of physicians to any degree. It was then that the disease first showed itself as an epidemic among the European armies, and was then called Opthalmia Militaris. In July, 1798, Napoleon I landed in Egypt with an army of 32 thousand men. Most of the soldiers were very soon attacked by a violent Opthalmia and were supposed to have brought it with them upon their return to Europe. This gave the disease the name of "Egyptian Opthalmia." It was however proven that the disease had been endemic in Europe for many years. It is endemic in our Eastern cities, especially among the foreign population, most of all among the Russians and Polish Jews and immigrants from Eastern Europe, generally, and among the Irish and

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Italians. It occurs frequently too among the Chinese and Japanese. It is also common and often in severe form among our native American Indians, particularly in some parts of the Middle West. In the mountains of Kentucky, West Virginia and Tennessee it is endemic. Dr. Stuckey of Lexington, Kentucky, who has established stations in the remote districts of the state traveling eighty-four miles by mule back, and treating endless numbers of the natives, said I have seen the disease existing in three generations with the grandmother blind in one eye and nearly blind in the other, holding a year old babe with the hot Trachoma tears dropping into the eyes of the child, not knowing it was infectious.

Trachoma is increasing in all of our rural districts. I think more because the disease is not recognized. Diagnosis is extremely important with Trachoma, because when seen early and the treatment is started early, the disease gives much less trouble. Many of the older opthalmologists who have written much about Trachoma are not willing to make the statement that Trachoma is ever cured, but that any inflammation or disturbance to the eye can cause the disease to break out anew. I am especially glad to tell you this old story, because of the dangers that will arise when our present boys in Europe return to their homes and mingle with the civil population.

I call your attention to the following report of the results of the Napoleonic wars in Europe. The armies came so repeatedly in contact with each other and the civil population, that the disease became more widely disseminated and occurred in epidemics. In some countries it became frightfully prevalent. In the English army during the year 1818 there were more than 5,000 on the Invalid List who had been rendered blind as a consequence of Trachoma. In the Prussian army from 1813 to 1817 twenty to thirty thousand men were attacked with it. In the Russion army from 1816 to 1839 seventy-six thousand eight hundred and eleven men were subjects of the disease. When they had so many Trachomatous soldiers in the Belgian army that they did not know what to do, the government applied to Jüngken who had then great repute as an opthalmologist in Berlin, he recommending them to dismiss the trachomatous soldiers to their homes. By means of this fatal measure, Trachoma soon became diffused in Belgium to such an extent that has been observed in no other European state.

EARLY GERMAN PROPAGANDA.

Our boys are going to return from mingling with the soldiers of all the countries of Europe, with the English, the French, the Belgians, the Germans, the Austrians, the Russians, in all of which Trachoma is now endemic, and worst of all from the prison camps of Germany, where I would not consider it beneath the Hun to deliberately spread the disease in the eyes of the American soldier, to further his possibility for winning the war.

Trachoma is a dangerous disease; there can be no doubt of the infectiousness of the disease; rarely have I found a family where only one member was affected. An investigation of Trachoma among the American Indians was made by the United States Health Service some three years ago, where in Wisconsin 2,999 Indians were examined, and 207 cases of Trachoma existed.

It is generally believed that Trachoma is due to some micro-organism proceeding from another eye affected with Trachoma. Infection takes place by transfer of the secretion by means of the hands, towels, handkerchiefs, dishes, and many other sources, wherever the secretion can get from one eye to the other. The transfer of the purulent trachomatous secretion to men have sometimes after an incubation period of eight to ten days resulted in the outbreak of Trachoma with acute inflammatory symptoms. It has been partially proven that the existing cause of Trachoma is a structure in the epithelial cells of the conjunctiva which has been named Chlamydozoon.

That it has not yet been more fully discovered, and a specific remedy found for its destruction is thought to be a reproach to the science and art of bacteriology and opthalmology. Dr. H. M. Foster of the United States Public Health Service, has classified Trachoma into two forms, the Fulminating Trachoma and the Slow Trachoma. He says: "The first is a very acute inflammation which comes on suddenly and is accompanied by the usual symptoms of a severe infection of the conjunctiva. There is redness, swelling, lachrymation, photophobia, pain, and marked thickening of the lids. Slow Trachoma seems to be the best term to apply to the ordinary forms of the disease. At the first blush it would appear that chronic would

be the proper adjective to use, but the condition referred to under the second heading may be either acute or chronic, hence, the name Slow Trachoma."

In the acute stage there is an infectious, purulent secretion. It seems to be more highly contagious during the time of the excessive discharge. The disease almost always attacks both eyes. However, at the present time, I have a boy of twelve years of age whom I saw very early in the disease and directed him how to care for the opposite eye, and it has not yet been attacked. Pain, sensitiveness to light, lachrymation, sticking together of the lids, and visual disturbance are often the early symptoms. The affected eye is less widely open, in other words, a slight Ptosis exists. This is partly because of the photophobia, and because the heavy upper lid hangs lower down. At all times if the physician who sees an acute or chronic inflamed eye with a slight drooping of the upper lid would make the rule to examine carefully for Trachoma, it would be an important step in the discovery of the disease. Many times it is not easy to diagnose an acute case of Trachoma on the first visit because it can be easily confused with Follicular Conjunctivitis.

Conjunctival trouble caused by Syphilis, Parinads, Conjunctivitis and caterpillar hairs, or small foreign bodies which have penetrated into the tissue of the conjunctiva. There are small velvet appearing granules or even raspberry like projections which are discovered on inverting the upper lid that are very characteristic in the acute stage, the fulminating stage or the first form. In the second stage the chronic stage or as called above the slow form it is more easy to diagnose. This is characterized by the presence of the true Trachoma granules. On account of their transculent appearance they have been likened to the eggs of frog spawn or the grains of boiled sago. The hypertrophy of the conjunctiva increases and the cartilage of the upper lid begins to show glossy between the rows of Trachoma granules, there may appear at this time some of the sequelae of Trachoma. If the case has not been carefully treated Pannus is one of the common complications, it is a deposit upon the cornea of a newly formed soft vascular tissue caused by the irritation of the Trachoma granules on the cornea and by some said to contain the micro-organism. Sight is much disturbed with Pannus from the start, the cornea is covered with fine blood vessels, and if associated with ulcer of the cornea can cause blindness.

The Iris participates in the inflammation and Iritis is not infrequent. The ulcers heal leaving behind them clouded spots, the influence of which upon vision is dependent upon their severity. Distortion of the lids with displacement of the Cilia is produced by contraction of the conjunctiva. The distortion of the lid progresses, the edge of the lid turns backward, which is called Entropion, which causes a permanent condition of irritation, this is caused by the constant contact of the lashes with the cornea and if not relieved diseases of the cornea are produced by the mechanical injury of the cilia. The eyelid may turn in the opposite direction, which is called Ectropion, and is usually found in the lower lid. Symblepharon is an attachment of the conjunctiva of the lower lid to the ball of the eye caused by the inflammation of the conjunctiva. This can be seen by drawing the lower lid down and a very fine band can be seen connecting the eye with the lid.

One of the worst sequelae or complications of Trachoma is Xerosis, it means a dryness of the eye. It looks as if oil had been instilled into the eye, the eye suffers markedly from the lack of moisture. This produces what is called Xerophthalmus, and which forms the worst termination of Trachoma. The eye is much disfigured and incurably blind, and tortures the patient with a constant sense of dryness. I wish to emphasize the care that should be taken by every physician, and if they are doubtful of their diagnosis (as mentioned above it is difficult to distinguish other diseases from Trachoma on the first examination, especially in case of acute onset) it is wise to brand these chronic cases as suspected Trachoma. The physician should take the necessary steps to avoid the spread of the disease, and must use the treatment generally recommended. If this treatment in a short time leads to rapid improvement of the inflammation and lessening of the size of the granules the case is *not* Trachoma, because Trachoma is much more obstinate. The correct diagnosis may be made if it is possible to find the presence of the existing organisms of Trachoma. It is not easy, however, to prepare and stain the organisms. The patient should be told what the disease is and the care necessary to prevent spreading the disease. As stated above, Trachoma is a dangerous disease.

Great care should be taken to keep watch of the

eyes of the children in public schools where cases of Trachoma have been discovered. Trachoma is more liable to spread in institutions of any kind for the poor, in prisons, in institutions for children, schools for the blind, barracks, and poorly ventilated homes. Trachoma flourishes excessively among the overcrowded, underfed, overworked, and those living in bad hygienic surroundings generally. No locality or race is exempted, and occasionally cases are found among the well-to-do, and those whose methods of living is above reproach from a sanitary standpoint. I have seen children as young as two years with the disease, and have found adults to contract the disease well past middle age. One of the serious difficulties in combating the disease is the discharging of patients before they are cured. When an eye has become affected with Trachoma it is liable to recur as long as any normal conjunctiva remains.

As previously mentioned the infection lingers in the granules apparently indefinitely and some trifling local irritation or constitutional disorder may cause it to spring up into renewed activity at any time. In fact if the disease can be cured at all it can never be said to be completely cured until all the conjunctiva of the upper lid has become completely replaced by smooth, white, vascular, fibrous scar tissue and the lower lids free from any evidence of the disease. Vascular tissue cannot be infected by the virus of Trachoma.

Strange to say Trachoma through all time has been treated very much the same as it is now. Many improvements have been made in the hygienic and surgical treatment, and I believe the time will come that it will be a disease that will be quarantined. For many years the 2 per cent solution of silver nitrate brushed on the lid, or sulphate of copper applied to the lid in the form of a stick have been recognized treatment. Solution of bichloride of mercury 1-5000 to 1-500 have been used extensively. Two per cent yellow oxide of mercury and boracic acid play an important part in the treatment. Dr. J. P. Cawford of Nashville, Tennessee, has had extensive experience with the Bulgarian Bacillus treatment from which he reports most excellent results. He uses the powder. Dr. Frank Allport of Chicago, advocates the use of powdered boracic acid following the squeezing of the Trachoma organism out of the Trachoma granules with Kuhnts Trachoma Forceps. This forcep is similar to a blunt tissue forcep. One blade is flat and smooth, this is used in contact with cuticle side of the lid. The other blade is smooth and perforated with little holes, and is applied on the conjunctival side of the lid. The use of this instrument causes but little disturbance of the conjunctiva.

In any of the complications of Trachoma, where there is inflammation of the iris, atropine should not be forgotten, because if the iritis is allowed to continue, synechia of the iris follows and the complications are increased. Many oculists use the Knapp roller forceps to destroy the Trachoma granules. In any of the sequelae of Trachoma where the distortion of the lids takes place, operative treatment is necessary. Tarsectomy or the excision of a part or all of the tarsus is necessary in severe cases in adults. The radical operation on children is not advised. Opening or cutting through the Trachoma granules is Grottage, and Grottage is sometimes used with Brossage, or with pressing the granules out by means of some of the trachoma forceps.

I have endeavored to mention only such treatment as is recognized; so much has been written and so many suggestions made that careful selection of treatment is wise.

At this time it is particularly of importance to refresh our minds on such diseases as are epidemic and endemic in large groups of men, of many nationalities, constantly in contact with each other, who in time will have to return into civil life. In the large cities of the States, better care is given cases of Trachoma than in the small towns and isolated districts, because the disease is discovered and the opthalmologist is at hand to treat them. I have found a good many untreated cases of Trachoma from the rural districts, which with the renewed exposure on the return of the soldier may greatly increase the number of cases of Trachoma.

In preparing this paper references have been made to the writings of John Weeks, DeSchweinitz, Swansey, Wood, Fuchs, and many medical journals.

Trachoma: Its influence upon the civil population on the return of the soldiers to their homes.

DISCUSSION.

Dr. Chapman: I think that this paper is very opportune. Dr. Dwight has covered the subject very thoroughly. I believe with him that trachoma is much more prevalent than generally believed to be; especially in

the attenuated form. Right here in Milwaukee in the dispensary it is the borderline case in which the diagnosis is very difficult to make. Very often if we will follow up the history of the case closely, with the aid of a visiting-nurse, we will find that the mother or the grandmother or somebody in the family has trachoma. The use of bichloride of mercury is very good; but it has always seemed to me that the cyanide of mercury is better. The cyanide solution can be used much stronger than the bichloride with less irritation to the conjunctiva, and at the same time it does more good than bichloride for the reason that bichloride combines with the albumen of the tissues very readily and does not penetrate well. The cyanide does not make such a combination, and I believe is much better than the bichloride. You can use 1 to 500 solution without any trouble. At the Illinois Charitable Eye & Ear Infirmary where I was an interne years ago, we used to have 35 or 40 trachoma cases all the time—new cases all the time. They came from southern Illinois, a place called "Little Egypt," some of them most distressing cases. And in spite of everything we could do, they would stay month after month under treatment without very much improvement. We found in many of the cases, especially those with eyelashes touching the cornea, that we gave a great deal of relief by the grafting of mucous membrane from the mouth into the eyelids margins. Those grafts will take very readily; hardly ever one of them failing; and in place of there being rough scar tissue or eye lashes rubbing on the cornea there was a soft mucous membrane. Some of these cases of trachoma, which are very distressing, will clear up readily after the mucous membrane graft has been inserted.

Dr. Dwight: I rather think I am in quite a trachoma district. We are in the milk district, and in those factories, foreigners have come in from countries where trachoma is edemic, and in our district I believe we see as many cases as you do here. There is something better than a thousand cheese factories in western Wisconsin, and every cheesemaker in the entire section has some member of the family affected. All those counties where they have been brought in, the children go into the district school and it is the district school that is spreading trachoma. For instance, one case is the son of the principal of the schools in a village where the sanitary conditions are absolutely ideal in the home.

It is related that an old Atchison colored woman who has a great many children, takes in washing, and works like a slave, was called upon by a doctor and a health officer last winter, during the smallpox excitement, who told her she must be vaccinated. The old colored woman was good and mad. She said she had no time to stop to be sick with vaccination, and, besides could not spare one of her arms; that the children would starve and freeze if she could not do her laundry work. Then the doctor said: "Well, auntie, I will vaccinate you on one of your lower limbs." "No, siree," said the colored auntie, "I can't spare one of my legs either." Then the doctor said kindly: "Well, what spot could you spare, because you must be vaccinated." The old colored woman thought and thought, and finally said slowly. "Well, Lord knows; I don't never get no chance to sit down."—*Atchison Globe.*

SPOKE TOO LOUD.

"Where is Sam, George?"

"In de hospital, sah."

"In the hospital. Why how did that happen?"

"Well, Sam he been a-tellin' me ev'ry mornin' foh ten days he gwine to lick his wife 'cause o' her naggin'."

"Well?"

"Well, yestiddy she done ovehheah him, dat's all."—*Los Angeles Times.*

TUNEFUL TONSIL TALK.

Mary had a little cough,
  Its bark was loud and sneezy,
And everywhere that Mary went
  That cough was always wheezy.
It went with her to school, of course,
  And met the school physician,
Who found her adenoids were large,
  According to his mission,
But now those horrid adenoids,
  Her cough and tonsils vicious,
Repose upon a doctor's shelf,
  And Mary feels delicious.

THE ARMY NURSERY.

Four little nursies sitting 'neath a tree,
  Along came a Major and then there were three.
Three little nursies looking very blue,
  A Captain toddled up and then there were two.
Two little nursies feeling they'd be done,
  But long came a Loot which left only one.
One litle nursie ready for a cry,
  Private saunters up—but walks right by.

—L. F. S.

"Public Health is purchasable," says the United States Public Health Service, and adds that a first-class health protection service can be provided for one dollar per head per year. In fact some city health departments render excellent service at a cost of seventy-five cents per head. Let's all get together and give better support to health work in this community.

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ROCK SLEYSTER, M. D., Editor
Wauwatosa

J. P. McMAHON, M. D., Managing Editor
141 Wisconsin Street, Milwaukee

Publication Committee:

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JOS. SMITH, M. D., Wausau
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EDITORIALS

MEDICAL VETERANS OF THE WORLD'S WAR.

MENTION has been made in recent issues of the Journal of the formation in the Surgeon General's office of an association of "Medical Veterans of the World's War." The idea of associating physicians who volunteered their services to the country in the war for developing professional amenities and advantages has proven very popular. Several states are forming such associations and are applying to the parent organization at Atlantic City for recognition as a constituent branch association. The first meeting of the national association will be held in Atlantic City during the second week of June. A permanent organization will be accomplished at that time.

Distinctive badges have been ordered for members and the American Medical Association has offered the use of a large auditorium for a meeting on Friday night of that week, the program for which will be announced later.

The constitution and by-laws of the new association will be found in this issue of the Journal under the section "Medical Mobilization and the War." It will be noted that all medical officers, contract surgeons of the U. S. Army, and acting assistant surgeons of the U. S. Public Health Service, who have served in the medical corps of the U. S. Army or Navy or U. S. Public Health Service, are eligible for membership. In addition to these, all medical members and examiners of Local, Medical Advisory and District Boards, officially appointed by the President of the United States, the Provost Marshal General of the U. S. Army, and the Governors of the various states, are eligible.

As the object of this association is to perpetuate fellowship, to prepare history, and to secure cooperation for the mutual benefit of the medical men who served in the World War, and as the association has the approval and backing of the Surgeon General's office and the American Medical Association, it would seem desirable that all medical men eligible for membership should make application at this time.

Dues may be sent to Colonel F. F. Russell, Army Medical School, Washington, D. C.; Colonel Hubert Work, Pueblo, Colorado; or to Major Rock Sleyster, temporary secretary of the local organization, Drawer D, Wauwatosa, Wisconsin. A blank application will be found on page 501 of this issue.

(Since writing the above we are advised that Col. Russell has been ordered abroad and that initiation fees and dues (one dollar) should be sent to the secretary of the local organization.)

THE JOURNAL CLINIC.

THE Journal Clinic is at last a reality. This department has had the serious consideration of the Publication Committee for some years past.

The value of clinical teaching has never been so appreciated as at the present time, and there has been a popular demand for a regular monthly clinical department in the Journal. The department was begun in the April issue and the universal approval with which it was received has led to a determination to continue it as of equal importance to the original articles.

Its success is guaranteed by the agreement of Drs. L. M. Warfield of the Marquette University Medical School and J. S. Evans of the University of Wisconsin Medical School to stand responsible for it. The readers of the Journal are invited to send any correspondence regarding the department or the clinical cases reported direct to the editors.

OVERDOING IT.

THE attempt to exploit their war service being made by some medical men returning from the army approaches, we fear, dangerously near the elasticity limit of medical ethics. Men returning from a few months' service in the camps and cantonments, in some instances, at least, have inserted paid advertisements announcing that they have had an "immense clinical experience" in this or that, and by virtue of this newly, not to say rather quickly, acquired high degree of special skill will henceforth condescend only to do consultations or will limit their work to the surgery of the heel or what not.

To the man in the street it is not exactly clear just how a few months or weeks of service in the sanitary corps, for instance, eminently qualifies a man for specializing in surgery, or how attending cases of influenza, measles, etc., in an army hospital renders him at once an eminent gynecologist.

We have been told that the war will work wonderful regeneration processes in men and nations. Surely if we are to swallow some of the stuff or any part of it being handed out by some of the men returning from service, we will have to rub our eyes and pinch ourselves like Rip van Winkle and when we awake from our sleep we shall probably find that some of these men have accomplished in twenty minutes what it took the rest of the world twenty years to do. J. F. S.

PUBLIC HEALTH AND LABORATORIES.

THE Journal has received many compliments on its new department, "Public Health and Laboratories," which was established a few months ago and which is edited by Dr. W. D. Stovall, Bacteriologist to the State Laboratory of Hygiene at Madison, and Mrs. Louise F. Brand, publicity agent of the Wisconsin Anti-Tuberculosis Association.

The editorial staff feels that too little attention has been paid to public health matters by the busy general practitioner and specialist, and hopes that this department will stimulate a new interest in the subjects which are here brought to them.

The attention of our readers is especially directed to a new series of three articles by Dr. Stovall, the first of which deals with methods used in promoting public health and which is published in this issue. In the next article, Dr. Stovall will discuss the present health measures as they are carried out and point out how they could be carried out if all of the scientific facts which we have accumulated concerning the spread of disease were properly applied. In the third paper, he will write on the necessity of a centralized health service and work in some of the details of such a service.

EFFICIENCY.

AT a recent meeting of English physicians one doctor, according to the newspapers, pointed out that Charlie Chaplin gets $1,500,000 a year for making people laugh while he (the doctor) gets only $3,500 a year to keep them alive. Does that prove that a laugh maker is more appreciated than a doctor? Perhaps, but I do not think so.

If Charlie Chaplin were visiting his clients personally and compelled to take such laugh making equipment with him as could be carried in a handbag, he would not be making as much as the average doctor is now making. Charlie's earnings are high because his clients are so many and he can serve each at a very small sum indeed.

Curative medicine can not be practiced competently on any such large production scale as moving pictures can be produced. But it can be put upon a much more economical basis than it is on now by combination and by employment of a larger number of low salaried technicians each able to

carry out a detail as conscientiously and competently as a general practitioner can. H. E. D.

TUBERCULOSIS.

IS the diagnosis and treatment of tuberculosis, a disease which causes one-eighth of all human deaths and one-eighth of all human illness, worthy of recognition as a distinct specialty? It is needless to recall the slight attention accorded to work on this subject until recent years when the public, awakened by the efforts of such organizations as the Anti-Tuberculosis Association, have demanded an attention to tuberculosis never dreamed of a few years ago.

The attention of the Journal readers is directed to the article by Dr. George Thomas Palmer, reprinted in this issue from the Illinois Medical Journal of February, 1919. There can be no question that this new old field offers opportunity spelled in capital letters to the physician with a determination to give it his whole attention, providing he is endowed with a very necessary social instinct.

THE OCTOBER MEETING.

THAT our expectations for the best meeting of the State Society ever held will be realized next October, is assured by the following letter from Dr. Charles H. Lemon, chairman of the Program Committee:

"At the Mid-Winter meeting of the Program Committee appointed by the President of the State Medical Society, it was decided to make the coming meeting a War Meeting.

"The Medical Officers of the 32nd Division, of Base Hospital 22, and other units which were served by Medical Officers from Wisconsin, have performed a work which the members of the State Medical Society have expressed a desire to hear described.

"During the Civil War, Wisconsin medicine distinguished itself, but did not excel the work performed by the men of the 32nd Division and Base Hospital 22. We are all proud of that record and it would be a signal honor for Wisconsin medicine to gather together in concrete form at the next State Meeting the record of the achievements of our own Fellows.

"In view of this fact, no other subjects will be presented at the meeting; no outsiders will be invited, as there are none more distinguished than those within our own midst, and we hope to present a program which will meet approval of the members of the society and at the same time collect together the most interesting story of the achievements of medical science during the greatest War mankind has known.

Very truly yours,

CHAS. H. LEMON,

Chairman, Program Committee."

THE JOURNAL CLINIC

Edited by
L. M WARFIELD, Marquette University
and
J. S. EVANS, University of Wisconsin

(Address all communications direct to the editors)

FROM THE CLINIC OF THE UNIVERSITY OF WISCONSIN.

J. S. EVANS.

A series of cases having a similar symptom complex but with different underlying causative pathology is presented.

CASE I. A. N. Married. White. Female. Age 28.

Chief Complaint: Gnawing, burning pain in the epigastrium.

History of Present Illness: The present complaint began about four years ago with burning, gnawing sensation in the epigastrium, from three to four hours after meals. These pains which have continued up to the present time are not continuous in type and are usually relieved by the ingestion of food. The pain is localized to the epigastrium with occasional reference to the back. There has been no attendant nausea or vomiting. Gaseous eructations are common. The bowels tend to constipation and blood has been noted in the stool. The appetite is poor at present; the dietary is restricted to bread and milk. No symptoms referable to respiratory, cardio-vascular or genito-urinary systems.

Past Medical History: Appendectomy was performed five years ago. Adenectomy (suppurative cervical adenitis) one year ago followed shortly by tonsillectomy. Never Jaundiced. Otherwise past medical history has no bearing on the present condition. Menstrual and child-bearing history normal.

Family and Social History: No bearing on the case.

Physical Examination: The only finding with direct application to the present condition is marked tenderness along the greater curvature of the stomach.

Blood: Moderate chloranemia with a normal numerical and differential leucocytic picture.

Wassermann: Negative.

Urine: Negative.

Roentgenologic:

Radiographic:

Outline of the stomach is regular with the exception of a small incisure on the lessure curvature three or four fingers' breadth from the pyloric ring. This is constant in all of the plates. There is an incontant irregularity of the duodenal cap.

DISCUSSION.

The symptoms of gastric hyperacidity, the history of an earlier attack of appendicitis and the roentgenalogic report all directed attention to the probable existence of a gastric ulcer. The progressive character of the symptoms led to exploratory laparotomy. The surgeon reports the following: "A band attached to the greater curvature of the stomach and attached above produced when the stomach was distended, an hour glass type of contracture of that organ." This band of adhesions produced an obstruction to normal gastric peristalsis which was responsible for the ulcer-like type of incisure leading to the radiographic report. It likewise produced reflexly both the pyloro-spasm and hyperacidity.

This case illustrates the difficulty of diagnosing gastric ulcer even with apparent confirmation of the clinical findings by the radiogram. Without a doubt the history of melena was misguiding in this case and probably resulted from hemorrhage lower down in the intestinal tract (hemorrhoids).

CASE II. C. K. Married. White. Female. Age 27.

Chief Complaint: Gnawing, burning pain in the epigastrium and along the right costal margin.

History of Present Illness: Shortly following an operation for appendectomy three years ago these epigastric pains were first noted. From their onset radiation to the back in the dorso-lumbar region but more particularly to the right scapular region has been the rule. These pains bear no relation to meals nor are they relieved by the taking of food. The character of pain may charge to sharp colic during the more serious attacks. During the last gestation (two years ago) an exacerbation of symptoms was remarked. At no time has there been nausea or vomiting. Constipated. No further noteworthy symptoms elicted.

Past Medical History: Subject to tonsillar and nasal infections. Mild attack of rheumatic fever four years ago. No history of jaundice. Menstrual and child-bearing history normal. Two children.

Family and Social History: Negative.

Physical Examination revealed the following points of note:

Heart: Reduplication of the first sound at the site of the cardiac impulse with an indistinct presystolic murmur.

Abdomen: Palpable mass in the right hypochondrium, apparently in the position of the gall bladder.

Urine and Blood: Negative.

Roentgenologic: Barium meal.

Fluoroscopic: Duodenal cap irregular but this irregularity is inconstant.

Radiographic: Contour of stomach normal. Peristalsis normal. Gastroptosis. Gall bladder shadow distinct showing marked enlargement, containing many soft stones.

DISCUSSION.

The symptoms of gastric hyperacidity, of spastic colitis, pain radiating from the right costal margin to the right scapula, the probable relationship of the past medical history of appendicitis and frequent tonsillar infections, and the physical and roentgenologic findings pointed rather definitely to cholelithiasis and chronic cholecystitis. The similiarity of this case to Case I as to age, sex, social conditions, duration of symptoms, and past medical history of tonsillar and appendiceal involvement, is noteworthy. A definite difference in the following points as to pain, however, should be remarked; namely, in the present case the pain bore no relation to meals nor was it relieved by the taking of food. The location and radiation of pain definitely indicated gall bladder involvement rather than gastric ulcer. Finally, the radiographic finding gave positive evidence of cholelithiasis, confirming the findings on palpation. Operative findings confirmed this diagnosis. The gall bladder was the seat of marked inflammatory changes and contained many stones of varying sizes.

CASE III. J. T. Married. White. Female. Age 24.

Chief Complaint: Burning pain in the epigastrium and right chest.

History of Present Illness: The present condition began two years ago succeeding parturtion with a severe attack of upper abdominal pain, associated with con-

siderable nausea and vomiting. Recurrences of similar attacks continued every two or three days for several months or until the administration of olive oil. After an interval of freedom from pain lasting several months a severe recurrence succeeded an attack of grip. It was remarked that this recurrence instituted a continued period of abdominal tenderness and heaviness. Furthermore, a series of more frequent attacks ensued. Jaundice of a low grade has succeeded these exacerbations. The appetite continues good. The bowels are regular.

Past Medical History: Shows only a susceptibility to nasopharyngeal infections. Menstrual and child-bearing history normal.

Family and Social History: Negative.

Physical Examination: Except for a soft systolic mitral regurgitant murmur there were no noteworthy findings.

Blood and Urine: Negative.

Roentgenologic: Both fluoroscopic and radiographic examinations were negative.

DISCUSSION.

This case differs from the preceding ones in that the continuous upper abdominal pain succeeds a colicky attack and that in exacerbations of these symptoms the colicky pain is the predominant one. The nature of the pain and frequent exacerbations direct the attention primarily to the gall bladder. The occurrence of jaundice after such attacks would point to obstruction either in the hepatic or the common duct. The negative roentgenologic findings do not exclude cholelithiasis, since gall stones must contain pigment or some other dense substance in order to be differentiated from the shadows produced by the liver, kidney, or soft tissues. The diagnosis of cholelithiasis with cholecystitis was confirmed on operation by the determination of two small stones in the common duct and the gall bladder, the seat of chronic inflammation.

CASE IV. A. E. A. Married. White. Male. Age 38.

Chief Complaints: Epigastric discomfort, flatulencey, palpitation, and constipation.

History of Present Illness: Beginning six months ago, following an acute dental infection the patient noted marked flatulency and epigastric distress, which frequently was associated with palpitation. Insomnia resulted from an augmentation in symptoms and constipation became quite troublesome. Nausea but no vomiting.

Past Medical History: Severe attack of grip in 1916; otherwise negative.

Family and Social History: Negative.

Physical Examination:

Heart: Normal rate and rhythm. Soft systolic murmur untransmitted was heard at the fourth left costal cartilage (probably accidental).

Lungs: Negative.

Abdomen: Marked rigidity of the upper half of the right rectus is noted, with tenderness over Mayo-Robson's point. Definite resistance with the sensation of an underlying mass is determined, extending an inch and a half below the right costal margin, between the anterior axillary and mid-clavicular lines. Otherwise the physical examination was negative.

Urine: Negative.

Blood: Showed a moderate leucocytosis with relative increase in the polymorphonuclear elements (polymorphonuclear neutrophiles 72%, eosinophiles 4%, lymphocytes 21%, large mononuclears 1%, transitionals 2%).

DISCUSSION.

The history of the onset of symptoms as a possible sequella to dental infection, the presence of definite physical signs in the right hypochondrium, and the moderate polymorphonuclear leucocytic reaction, together with the nature of his complaints, all pointed toward a subacute involvement of the gall bladder. With such an inflammatory condition in mind, and regarding the gastro-intestinal manifestations as secondary, palliative treatment was instituted. Three weeks later there was a sudden severe attack of abdominal cramp, beginning in the right hypochondrium, radiating into the right scapular region and to the lower right quadrant, associated with vomiting. On examination at this time there was elicited increased tenderness and rigidity in the right hypochondrium, the lower abdomen being relaxed and without tenderness. The leucocytes numbered 12,240, with a differential of polymorphonuclear neutrophiles 82%, eosinophiles 1%, lymphocytes 14%, transitionals 2%, mononuclears 1%, at this time. A radiogram at this time showed an increased shadow independent of the liver and kidney shadows, which was thought to be an enlarged gall bladder. Twenty-four hours later the pain, rigidity, and tenderness had subsided. The leucocytes had dropped to 8,000. But three hours later a severe attack of abdominal cramp occurred, the patient became shocked, and there was board-like rigidity over the lower right quadrant of the abdomen. A diagnosis of perforated appendix was then made. On operation the following findings were made: A retro-cecal appendix four inches in

length, greatly distended, containing a large proximal fecolith and perforated two inches from the tip. The case unquestionably presented the history, symptoms, and physical signs of gall bladder disease at the earliest examination. The subsequent course was such that we were unable even at operation to exclude cholecystitis because of the danger of generalizing the peritoneal infection. It is not improbable that the two conditions, appendicitis and cholecystitis, might have been coincident in this case, as in preceding cases (I and II).

CASE V. W. J. S. Widower. White. Male. Age 29.

Chief Complaints: Sharp epigastric pain, loss of weight and weakness.

History of Present Illness: The condition started four months ago as rather severe pain in the right upper abdomen, lasting about three days. This was succeeded by a severe gnawing pain in the epigastrium which was continuous, aggravated by eating and not relieved by further eating. It is more severe in the afternoon and evening and is accentuated by physical exertion. On walking the pain is associated with a severe bearing down sensation in the abdomen. There is no nausea or vomiting. The bowels are normal. He has lost thirty pounds in the past seven weeks and has become very weak. Marked tarry stools were noted at first but the blood more recently has been merely occult. The patient gives a history of showing considerable blood in the test meal removed some weeks ago. There are no symptoms referable to the respiratory, cardio-vascular, nervous, or genito-urinary systems.

Past Medical History: Elicits nothing of etiologic importance except the existence of an alveolar abscess which is just healing.

Family and Social History are without bearing on the case.

Physical Examination: In general appearance the patient is very pale, almost cachectic.

The abdominal examination alone is worthy of note. There is very marked tenderness in the epigastrium with slight rigidity. The liver extends about a finger's breadth below the costal margin.

Roentgenologic examination: Shows distortion of the duodenal cap with a possible filling defect of the lesser curvature near the pylorus.

DISCUSSION.

With the history of the acute onset, the nature of the pain, and the rather abundant hemorrhage, together with the roentgenologic findings, in spite of the loss of weight and apparent cachectic condition, a diagnosis of ulcer at the pyloro-duodenal junction was made, and operation advised. Laparotomy determined some free fluid in the peritoneal cavity. The liver was studded with carcinomatous nodules. The pyloric end of the stomach showed an indurated mass which particularly involved the lesser curvature close to the pylorus. A frozen section verified the nature of these nodules at the time of operation. In this case the age, history of the onset, and the nature of the pain, were particularly misleading. The roentgenologic findings were readily explicable by reason of the nature of carcinomatous involvement.

GENERAL DISCUSSION.

This group of five cases has been presented with a view of demonstrating a similarity in subjective symptoms, history of onset, and previous medical history (a majority of instances).

Indeed, the gross physical findings were in these inconclusive, so that the differential diagnosis depended largely upon either cardinal symptoms or roentgenological findings. In a general way the group might be classified as one showing gastric hyperacidity, a symptom complex usually indicative of remote organic lesions. These more remote processes may influence the secretory and motor functions of the stomach, either reflexly or directly and may arise, as in the group of cases presented, in gall bladder, appendix, or gastro-intestinal tract. So difficult is the differentiation of these conditions that every available method of precision should be employed. With the exception of the latter stages of gastric carcinoma there is a tendency in each of these conditions for not only an increase in the total gastric acidity but an actual hyperchlorhydria. Symptoms of hyperacidity most frequently are reflex in origin, as we have endeavored to indicate by these selected cases, and it is only since the use of the X-ray in determining the motor activity of the stomach that we have been definitely able to reduce the error in attributing such symptoms to organic changes in the stomach itself. The presence or absence of abnormal filling defects, the lengthening of emptying time, and abnormalities in contour or in the persistance of barium shadows, all have their diagnostic weight. The first four of these cases illustrate an apparent etiologic relationship between upper respiratory or dental infections and inflammatory processes in the appendix, stomach, and gall bladder. In any consideration of upper abdominal pain of the nature described, lead colic, the gastric crisis of tabes, and renal calculi must be eliminated.

FROM THE CLINIC OF THE MILWAUKEE COUNTY HOSPITAL.

L. M. WARFIELD.

CASE 1. A young draughtsman's helper eighteen years old came to hospital on March 3, 1919, complaining of painful and frequent urination. In the family history his mother died at the age of thirty-six of tuberculosis. Otherwise the history is of no importance.

He has always had splendid health, never ill a day in his life until about five years ago when he had appendicitis. This was a typical acute attack. On October 16, 1918, he entered hospital with pain in the side, fever, etc. Appendectomy was performed in the hospital, October 17. The operative diagnosis was subacute appendicitis with adhesions.

He places the beginning of his illness very definitely on November 20, 1918, when he noticed frequency and burning urination. He thought at that time the urine was cloudy. Since that time urination has become more frequent until now he is voiding about every two hours during the day and two to three times during the night. About February 25, he first noted blood in the urine. In the morning he passes clots of blood and pus after which the urine remains clear for the balance of the day. He has much pain referred to the head of the penis after voiding.

He denies gonorrhoea or syphilis. He has not lost any weight (average 140 pounds), and his appetite, digestion and bowels are o. k.

On examination he was a well developed, well nourished young man. Pupils equal, and react normally. Teeth and pharynx normal. Slight post-cervical adenopathy. The chest organs revealed nothing abnormal. On the abdomen was an appendectomy scar. The right rectus was a little more tense than the left and deep pressure elicited pain. Supra-pubic pressure produced pain referred to the head of the penis. No palpable masses are made out. There was no hernia. The extremities were well developed, negative to examination. The external genitals showed no abnormalities. The prostate was of normal size and consistency.

Urine:

A. M. Specimen. Mar. 4.
Specific gravity 1020.
Turbid, amber.
Albumen—positive.
Sugar—negative.
Reaction acid.
Miscroscopic: Many pus cells, few r. b. c., bacilli.

Urine:

Catheterized specimen. Mar. 6.
Specific gravity 1022.
Turbid amber.
Acid.
Albumen—positive.
Sugar—negative.
Miscroscopic: Many pus cells, few r. b. c., acid fast bacilli.

Cystoscopic Examination: March 6, 1919.

Meatotomy done. Cystoscopic findings. Right ureteral orifice greatly congested. Left patent. Blood clot 1 cm. in dia. on bladder wall and is not movable. Patient to return for ureteral catheterization in one week. (Dr. Fletcher.)

Cystoscopic Examination: March 10, 1919.

Unable to catheterize right ureter. Catheter passed into left ureter with difficulty. Specimen collected from left ureter.

Miscroscopic examination of specimen collected from left ureter is clear and shows no evidence of pus or micro-organisms. (Dr. Fletcher.)

Phthalein Test: March 26, 1919.

1.0 c.c. injected at 3:50 P. M.
1st hour 30%.
2nd hour 12%.

Nephrectomy: March 27, 1919. (Dr. Fletcher.)

One deep cigarette drain. Glycerine dressing.

Anatomical diagnosis: Tuberculosis of kidney.

The kidney was nodular, somewhat enlarged and the whole upper third was composed of a thin walled cyst of cloudy fluid. On cut section the cortex is thinned, the papillae in the upper third are destroyed, in the rest of the kidney partly destroyed. Several cheesy nodules are in the medulla, the largest measuring 1½ cm. near the lower pole. Tubercle bacilli in great numbers were found in the cheesy material.

The patient has had an uninterrupted convalescence.

DISCUSSION.

The history of frequent urination is the most suggestive symptom for the diagnosis of tuberculosis of the kidney. It is of course due to bladder irritation and cystitis as the result of secondary infection from a kidney. Although it is possible to have an ascending infection from primary tuberculosis of the bladder this path is most unusual. The natural route is blood infection of a kidney, then infection of the bladder from the tuberculous urine. A secondary colon bacillus cystitis often supervenes and tends to obscure the diagnosis. In every such case a carefully catheterized specimen should be obtained and the specimen centrifuged. The sediment is washed with distilled water and again centrifuged. The sediment is now spread on a slide, dried, and stained in the usual way for tubercle bacilli. If the catheterization has been carefully done the chance of confusing smegma bacilli with tubercle bacilli is reduced to a negligible factor.

Before one kidney is removed the ureters should be catheterized and assurance gained that there is one sound kidney.

Tuberculosis of the kidney, as in this case, may

come on rather acutely and the incapacity may be very slight. The complaint in the majority of cases is frequency of urination or cystitis.

Treatment consists in removal of the kidney. Even if the bladder is ulcerated there is no necessity for any radical treatment of it. The cystitis clears up quickly after the source of infection is removed.

CASE 2. A Pole, aged forty years, tanner by occupation, entered hospital March 15, 1919, with complaints of weakness and discolored legs. He has always been strong and healthy; came to this country two years ago; cannot speak English. For the past several years he has had to get up once at night to pass urine. He does not drink. His occupation is a hard one and he lives in more or less squalor.

His present illness began about four weeks prior to admission when he noticed that he was becoming weak and that his thighs were discolored as if they had been bruised. This discoloration he thought had much increased following a fall on the sidewalk. His appetite and digestion were good.

On examination he was a poorly nourished man, the mucous membranes were anemic, the teeth were covered with sordes, the tongue was coated, the breath was foul and the gums were distinctly swollen. The chest and adominal organs showed no abnormalities. The upper extremities were negative. Both lowers were swollen. tense, hard, not edematous. From the thigh to the ankle, the legs are discolored a purplish tint fading to blue and yellow. The posterior surfaces are more discolored, the left leg more than the right. There is no pain, no loss of motion. No fracture or injury is found.

The temperature immediately after admission to hospital rose to 101° and then ran an irregular course for a week when it became normal and remained so. The pulse was never over 100. Respirations normal. Blood pressure 110 systolic, 80 diastolic. Leucocytes on admission 8500, differential count normal. Wassermann blood negative. Urine negative.

He was placed on a substantial diet containing fresh vegetables, meat and potatoes. Within two weeks he left stronger, his color was better and he had gained weight and the purpura on his legs had entirely disappeared. The leucocytes were 9000, the differential count normal.

DISCUSSION.

To one who had seen cases of this kind the diagnosis of scurvy was easily made. Had one never seen such massive purpura of the legs one might have been puzzled. Scurvy as we have seen it among the foreign born, particularly tannery laborers, has always been of the purpuric type. The gums are never very spongy or are the teeth very loose. Possibly we do not see the cases very early. One case I observed in consultation, had hemorrhages into both knee joints with petechiae on both lower legs. This case was also a Pole who lived in a hovel. One must however be careful not to miss a leukemia, particularly of the lymphatic type. Often spongy, bleeding gums is the first sign noted by the patient. The blood examination at once settles the diagnosis. The legs of the patients with scurvy such as this case, look as if some one had systematically beaten them up and down with a club. So injury has to be ruled out.

However, once seen, this picture is never forgotten. The efficacy of treatment is brilliant. Any kind of a good diet with potatoes, fresh vegetables and fruit rapidly produces improvement.

CASE 3. Pauline Tornan, five and one-half years old was admitted to the Milwaukee County Hospital Feb. 18, 1918, complaining of meningitis. She was a deaf mute. No history came with the child except that she had been ill for four weeks. On admission she lay in bed on her side with head thrown back. There was great irritability. The pupils were unequal, right larger, reacted to light. There was internal strabismus. She was comatose. There was marked rigidity of the neck muscles and apparently great pain on any attempt to flex the head. The pulse was regular, 120 beats to a minute. Heart sounds were clear. Nothing abnormal was found in the chest or abdomen. The knee jerks and Archilles' reflexes were diminished. There was a marked Kernig sign on both legs, a slight Babinski reflex bilateral. The child was quite emaciated. The temperature was 101° F. Urine and feces were passed in the bed involuntarily. Leucocytes were 13,000. A lumbar puncture was at once done. Thirty c.c. of opalescent fluid were withdrawn under pressure. The sell count was 700 per c.m.m. of which half were lymphocytes and half were polymorphonuclears. Globulin was present. A pellicle formed in 24 hours. No tubercle bacilli or other organism was found. Differential count showed nothing unusual. There were 69% polys. On Feb. 20th late in the afternoon a lumbar puncture withdrew 15 c.c. of fluid under no pressure. It was contaminated with blood. The meninges were washed out with 1% soda bicarbonate in normal saline and about 5 c.c. left in the meningeal space. There was no febrile reaction following this treatment. On the 21st the same procedure was done. The pellicle which formed in the spinal fluid was examined but no tubercle bacilli were found. On the 28th the following note was made. "The patient has become much brighter and shows more activity. The regidity of the neck muscles has diminished considerably. She now lies on her back with partial flexion of neck. The photophobia has disappeared. The pupils are still unequal and the strabismus is present. Kernig's sign is still marked. Until four days ago she was running a slight fever but since then the tem-

perature has been normal. The Babinski reflex cannot be elecited today. Daily lumbar puncture has been done for the past week and the meninges washed out with 2% sodium bicarbonate solution in physiological saline. The cell count today is 350 cells per c.m.m. Globulin is present. A pellicle forms on standing but no tubercle bacilli are found. The fluid is not under pressure. There are 60% of lymphocytes in the centrifugal smear. The leucocytes are 10,000." On March 7th the note was: "The temperature has remained normal during the past week. The general condition is much better. The physical signs are as in note of 2/28/18. Lumbar puncture is now made every other day and meninges washed as before. The cell count is 250 per cu.m.m. No organisms are found. The leucocytes are 11,000." On March 10th the count was "240 per cu.m.m. Globulin was negative." No puncture is to be done for a week. It is thought probable that the sodium bicarbonate is causing irritation and keeping up the cell count. On the 18th, 40 c.c. of slightly opalescent fluid were obtained under pressure. The cell count was 120 per cu.m.m. Globulin was negative. No organisms were found. On the 19th note was made: "Today there is slight stiffness of the muscles of the neck and a very positive Kernig's sign. The child is bright and seems well. The pulse is rapid." On the 20th she developed a sudden fever with headache. This proved to be the onset of a brief attack of erysipelas involving the left labium major and buttock. Lumbar puncture today withdrew 35 c.c. clear fluid under pressure. Cell count 60 per cu.m.m. Globulin negative. There was no clot on standing. The meninges was again irrigated.

She rapidly recovered from the erysipelas. Her condition was so good that no further spinal puncture was done. The strabismus was present. Evidently this had been present before her illness. After a month of running around the ward, apparently perfectly well she was discharged April 25th, 1918.

A guinea pig inoculated with sediment of spinal fluid did not show any lesion of tuberculosis.

DISCUSSION.

In spite of the fact that no tubercle bacilli could be found in the spinal fluid, the opalescent fluid with high cell count and lymphocytosis, the pellicle formation, the globulin, the physical signs seemed to point unmistakably to tuberculous meningitis. Unfortunately there is no record of a Wassermann reaction on the fluid. It is doubtful if it could have been syphilis considering the recovery under no specific treatment. The cerebral form of poliomyelitis was also taken into consideration. No such high cell count has ever to the writer's knowledge been found in this disease. Chronic cerebro-spinal meningitis is a possibility with the irritation causing the symptoms and signs after the meningococci had died out. However, the fluid in such cases is usually clear and the cell count is not so high.

The treatment was, so far as we know, unique. As much spinal fluid was withdrawn as possible. A syringe was then attached to the needle and ten c.c. of the 2% bicarbonate in normal salt was injected slowly. This was repeated two or three times and finally about 5 c.c. of the solution was injected and the needle withdrawn. The child had more than twenty punctures. No harm of any kind resulted and no reaction ever followed the irrigation of the meninges.

The child recovered. Our diagnosis was tuberculous meningitis. Had the child died with such symptoms and signs we should have felt reasonably sure of our diagnosis. Doubt is cast upon the diagnosis because the child recovered. This is the first case of recovery which has ever come under the writer's observation. Years ago in Arch. of Pediatrics, Charles Hunter Dunn reported several cases of recovery in tuberculous meningitis. Recovery certainly is exceedingly uncommon and most clinicians have had experience similar to that of the writer. This treatment seems devoid of harm and may prove to be of value in certain cases of meningitis.

(Continued in next issue)

UNITED STATES FEDERAL TRADE COMMISSION DISMISSES COMPLAINT FILED AGAINST THE VICTOR ELECTRIC CORPORATION LAST JUNE.

At a regular session of the United States Federal Trade Commission held in Washington, D. C., March 10, 1919, the complaint against the Victor Electric Corporation was ordered dismissed and discontinued. We congratulate the officers and members of the Victor organization on this vindication.

The personnel of the Victor organization is largely made up of pioneer workers in the X-ray and physical therapy field and we have always believed that these men, (who are directing the policies of the Victor Electric Corporation), have been actuated by a desire to elevate rather than to lower the standard of business ethics in their field.

The Victor Corporation is to be congratulated upon having had this opportunity of having the Government searchlight turned upon its activities, and the clean bill of health which the Corporation has received should be an inspiration to its officers to continue to be guided by those ideals which should be kept in constant view by all who are engaged in an industry so closely allied to medical science.

MEDICAL MOBILIZATION AND THE WAR

CONSTITUTION AND BY-LAWS OF THE MEDICAL VETERANS OF THE WORLD WAR.

Article 1.—Title.

The name and title of this organization shall be The Medical Veterans of the World War.

Article 2.—Object.

The object of this Association shall be to perpetuate fellowship, to prepare history, secure co-operation for the mutual benefit of the medical men who served in the World War, 1914-1918, and for the mutual improvement and social intercourse of its members.

Article 3.—Classifications for Membership.

Section 1.—The members of this Association shall be divided into two classes: (1) members and (2) associate members.

Sec. 2.—The following persons shall be eligible to membership in this Association.

1. All medical officers, contract surgeons of the United States Army and acting assistant surgeons of the United States Public Health Service who have served in the Medical Corps of the United States Army, United States Navy, and United States Public Health Service.

2. All medical members and medical examiners of Local, Medical Advisory, and District Boards, officially appointed by the President of the United States, the Provost Marshal General of the United States Army, and the Governors of the various states.

Sec. 3.—The following persons shall be eligible to associate membership in this Association:

Members of the medical profession of Allied nations who have been in service of their governments during the World War.

Sec. 4.—Associate members shall enjoy all the privileges of membership except the right to vote at the annual meeting.

Article 4.—Officers and Committees.

Section 1.—The following officers shall be elected at each annual meeting for the year ensuing:

A President (the same person shall not be elected President two years in succession); a Vice President at Large; one Vice President for each state and territory; a Secretary; a Treasurer; a General Council consisting of one member from each state and territory (the Council shall be a standing committee on nominations for office), and a Board of Trustees, which shall consist of seven members. The President, the Secretary, the Treasurer, and the last Ex-President shall be members ex officio of the Board of Trustees without the right to vote. The President, and in his absence the Vice President at Large, shall be the Chairman of the Board of Trustees.

Sec. 2.—The President shall annually appoint such standing and special committees as may be deemed necessary.

Article 5.—State Councils.

Section 1.—The Vice President for each state and not less than two other members from such state, to be annually elected, shall constitute a local council for such state to which shall be referred all applications for membership from such state. The Vice President shall be ex-officio Chairman of such council.

Sec. 2.—A committee of three, of which the Secretary shall always be one, shall be appointed by the President at each annual meeting of the Association, whose duty it shall be to report at the next meeting the names of all members who shall in the interval have died, with such notices of them as shall in the discretion of the committee be proper. It shall be the duty of the Vice President from each state to report the deaths of members within the same to the said committee.

Article 6.—Election of Members.

Section 1.—All elections for membership shall be made by the local council of the state in which the persons nominated reside. Such nominations must be transmitted in writing to the Chairman of the General Council and approved by the Council on vote by ballot. The General Council may also nominate officers of the U. S. Army, U. S. Navy and U. S. Public Health Service on active duty and members from states having no local council and at the annual meeting of the Association, in the absence of all members of the local council of any state.

Sec. 2.—All members of the convention adopting the constitution and all persons elected by them on the recommendation of the Trustees shall become members of the Association on payment of the annual dues for the current year herein provided for. During the period between the annual meeting members may be elected by the Board of Trustees on the written nomination of a majority of the Vice President and members of the local council of any state.

Article 7.—Dues.

Each member shall pay one dollar to the Treasurer as annual dues, and no person shall be qualified to exercise any privilege of membership who is in default.

Article 8.—Annual Meetings.

Section 1.—This Association shall meet annually at such time and place as the Board of Trustees may select, and those present at such meeting shall constitute a quorum.

Sec. 2.—The Board of Trustees and the General Council shall meet respectively in the forenoon and afternoon of the day preceding and in the same place as the annual meeting of the Association.

ARTICLE 9.—CONSTITUTION.

The word "state" whenever used in this Constitution and By-Laws shall be deemed to include state, territory, the District of Columbia, and the insular and other possessions of the United States.

ARTICLE 10.—ORDER OF EXERCISES.

The order of exercises at the annual meeting shall be as follows:

(a) Opening address of the President.
(b) Nomination and election of members.
(c) Election of the General Council.
(d) Reports of Secretary and Treasurer.
(e) Report of Board of Trustees.
(f) Report of standing committees.
(g) Report of special committees.
(h) Nomination of officers.
(i) Miscellaneous business.
(j) The election of officers and the Board of Trustees.

ARTICLE 11.—PAPERS.

All papers read before the Association shall be lodged with the Secretary and become the property of the Association, and shall not be published without the consent of the Committee on Publication, unless by the express direction of the Board of Trustees.

ARTICLE 12.—OFFICERS AND COMMITTEES.

SECTION 1.—The term of office of all officers elected at any annual meeting shall commence at the adjournment of such meeting except the Council, whose office shall commence immediately on their election.

SEC. 2.—The President shall appoint all committees within thirty days after the annual meeting and shall enumerate them to the Secretary, and the Secretary shall promptly give notice to the persons appointed.

ARTICLE 13.—TRUSTEES.

SECTION 1.—The Board of Trustees shall have control and management of the affairs and funds of the society.

SEC. 2.—After the first year, the Trustees shall be elected as follows: Three shall be elected to serve for a term of three years; two for a term of two years, and two for a term of one year, and thereafter for a term of three years to succeed those retiring. No Trustee shall be eligible to any other elective office, the term of which runs concurrent with the term for which the said Trustee has been elected.

SEC. 3.—The Board of Trustees shall fill any vacancy in its body until the next annual election after the occurrence of the vacancy.

SEC. 4.—The majority of the Board of Trustees shall be a quorum for the transaction of business.

SEC. 5.—Special sessions of the Board of Trustees may be called by the President of the Association on the written request of at least two Trustees. When a special meeting is so called, the Secretary shall mail a notice to each member of the Board of Trustees at least ten days before the day set. This notice shall specify the name, place and date of the meeting, and no other business shall be transacted other than that specified in said notice.

ARTICLE 14.—GENERAL COUNCIL.

The General Council shall elect annually a Speaker and Vice Speaker from its members. The Speaker, and in his absence, the Vice Speaker, shall preside over the meetings of the Council.

ARTICLE 15.—BRANCHES.

The Board of Trustees may create such constituent associations or branch organizations as may be deemed essential to promote the welfare of this Association.

ARTICLE 16.—DUTIES OF OFFICERS.

SECTION 1.—The President shall preside at the annual meeting and deliver an address on a subject of importance to the Association. He shall appoint such standing or special committees as may be deemed necessary.

SEC. 2.—The Vice President at Large shall perform the duties of the President in the President's absence. In the absence of both the President and the Vice President at Large, the duties of the President shall devolve on the Secretary.

SEC. 3.—The Secretary shall give due notice of the time and place of all annual and special sessions of the Association in such manner as shall be ordered by the Board of Trustees, provided that in the absence of such an order being made such notice shall be published in THE JOURNAL of the American Medical Association. He shall send an official notice of each annual or special session to the secretary of each local council. He shall keep the minutes of the Board of Trustees and the General Council. He shall notify the members of their appointment and of the duties assigned them. He shall verify the credentials of the members of the General Council, and shall provide a registration book in which shall be recorded the name of each member in attendance at such session, together with the name of the association, government service or section which he represents. He shall prepare a roll of the members attending each session to facilitate voting by roll call, and shall perform such further duties as may be directed by the Council or Board of Trustees.

SEC. 4.—The Treasurer shall be custodian of all the moneys and securities belonging to the Association and shall hold the same subject to the direction and disposition of the Board of Trustees. He shall give to the Board of Trustees a suitable bond for the faithful performance of his trust, the premium for which shall be paid out of the funds of the Association. He shall submit his accounts to an auditing committee appointed by the President, and shall make an annual report.

SEC. 5.—The Board of Trustees shall have the control

and management of the affairs and funds of the Association.

At its first annual session, the Board of Trustees shall elect from its members a Chairman and Secretary for the purpose of transacting all business.

The Board of Trustees shall fix the expenditures necessary for the offices of the Treasurer and the Secretary.

The regular meeting of the Board of Trustees shall be held immediately after the annual meeting, and special meetings may be called by the Chairman on the request of the majority of the Board.

ARTICLE 17.—SUSPENSION AND EXPULSION OF MEMBERS.

SECTION 1.—Any member who for one year has failed to pay his annual dues or assessments shall forfeit his membership thirty days after notice from the Secretary has been mailed to his last known address, but he may be reinstated on payment of his indebtedness.

SEC. 2.—None but associate members and invited guests shall be allowed to register or take part in any of the assemblies of the Association except as heretofore provided. No member shall be eligible to register at an annual meeting until he has paid all his incurred indebtedness.

SEC. 3.—The Board of Trustees shall have power by a three-fourths vote to suspend or expel any member from the Board and from the Association. Provided, however, that no one shall be thus suspended or expelled, save for nonpayment of dues or other indebtedness, until after written charges against him shall have been presented to the Board of Trustees and a copy of such charges has been served on him personally or has been mailed or delivered at his last known residence or place of business; and until, not less than five days previous to the date set, a notice has been mailed or delivered in like manner, stating the place and time when said charges will be heard by the Board of Trustees. On hearing such charges and the defense thereto, if any, the action of the Board of Trustees shall be final unless reversed by a three-fourths vote.

ARTICLE 18.

All meetings of the Association, the Board of Trustees, the Council and the Committee shall be governed by Robert's Rules of Order, when not in conflict with the Constitution and By-Laws.

ARTICLE 19.

This Constitution and By-Laws may be amended or repealed by the Board of Trustees at any annual session of the Board, or at a special meeting called for such purpose, provided notice in writing of the proposed change shall have been submitted to each member of the Board of Trustees at least ten days before the meeting, and providing that two-thirds of the voting members of the Board of Trustees registered at the session at which action is taken vote in favor of the suggested change or amendment.

Applications for membership and fee of one dollar should be mailed to the secretary of the state branch,

ROCK SLEYSTER,

Drawer D, Wauwatosa, Wis.

APPLICATION FOR MEMBERSHIP IN THE MEDICAL VETERANS OF THE WORLD WAR.

.....

City County State

.....

Number Street

.....

Date

I hereby apply for membership (or associate membership) in the *Medical Veterans of the World War.* I served during the period of the war as indicated below, as

1. An officer in the Medical Corps of the United States Army.
2. A Medical Officer in the United States Navy.
3. A Medical Officer in the U. S. Public Health Service.
4. A Contract Surgeon, United States Army.
5. An Acting Assistant Surgeon, U. S. Public Health Service.
6. A Medical Member Local Board No..... at.....
7. A Medical Examiner Local Board No..... at .....
8. A Member of the Medical Advisory Board at.....

I was appointed to the position checked above by

.....

I served from.....

to .....

I served in.....during the period

(The United States or in a foreign country; state where)

from .....

to .....

as .....

.....

(Brief history of service, giving units, dates and positions held; use reverse of this sheet and attach additional paper if necessary.)

.....M. D.

(Full name of applicant.)

REGULATIONS GOVERNING CONVERSION OF WAR RISK INSURANCE.

The regulations governing the conversion to standard forms of life insurance policies of all war-time term insurance taken out by soldiers and sailors since the entrance of the United States into the war have been approved by Secretary Glass. After conversion this insurance will be known as government life insurance.

The forms of policies which may be had in exchange for the war-time term insurance are: ordinary life, twenty-payment life, thirty-payment life, twenty-year endowment, thirty-year endowment and endowment payable at the age of 62. The premium rates for these converted policies are lower than those charged by private insurance companies. The policies contain exceedingly liberal privileges, providing for cash and loan values, paid-up and extended insurance, and further pro-

viding that the insured will be paid for life a monthly income in the event that he becomes totally and permanently disabled. All of these policies are incontestable from date of issue and are free from restrictions as to residence, travel or occupation. The holders of the policies will be eligible to share in and receive dividends from gains and savings and the proceeds of the policies are exempt from all taxation. Premiums on the new forms of government insurance are payable monthly and may be paid at any time during the month. They may also be paid annually, semi-annually or quarterly.

ARMY MEDICAL EXHIBIT.

On April 4 there was opened at the Army Medical Museum in Washington an exhibition of the medical activities of the war. The exhibit contains a plan of the proposed medical center at the Walter Reed Hospital, showing the architects' plan and sketches of the medical center, photographs of the present quarters and the military hospital at Fort McDowell, Calif. Another section is devoted to the work of the Roentgen-ray department of the Army, showing the different units and apparatus used during the war. A third exhibition concerns infectious diseases and laboratory detail of methods of combating infectious diseases, with a graphic representation of the results. The section on surgery shows, by photographs, methods of removal of wounded, transportation, types of hospitals, wax models showing the effects of mustard gas burns and other injuries and the Carrel-Dakin method of treatment. The section on orthopedic surgery is devoted to orthopedic devices, litters, splints, etc. The division on physical reconstruction illustrates the work of this department in caring for the wounded soldier and developing him so that he may be fit for useful industrial life. The section on neuropsychiatry exhibits by means of charts the work of that department; also by photographs of hospitals and cases displaying clearly some of the difficulties which this department had to overcome. Another section concerns the Army psychologic tests showing the successive steps in testing the mental capacity of officers and soldiers. Section 9 shows by legends and charts the results of physical examinations. Another exhibition is devoted to delousing, showing models of various delousing devices, and especially buildings equipped for this purpose. The food and nutrition division shows the results of the nutritional surveys, and by numerous photographs shows food and mess conditions in the various camps. Other sections display sanitation in the camps and sanitary appliances. The exhibit of the vital statistics division shows the use of the perforated statistical cards by which it is possible to rapidly determine the prevalence of various conditions. The final section, called the war museum of the Army Medical Museum, comprises three sections of materials received from France monthly since the beginning of the war, including weapons, rifles, machine guns, helmets, gas masks, pathologic specimens and wax models.

COURSES FOR STUDENT NURSES AT CIVILIAN HOSPITALS.

Arrangements are being made by the Surgeon-General of the Army with civilian hospitals for courses of instruction for student nurses. To be eligible for the diploma of the Army School of Nursing, students must complete the courses satisfactorily in both classes of hospitals. The arrangements with the civilian hospital training schools provide that the students in the Army School of Nursing shall be given board, lodging, laundry and such allowance, if any, as is given their own students. Some schools do not provide an allowance. During the period of their affiliation the monthly allowance of $15 from the Army will be discontinued.

NEW CHIEF OF SECTION ON HEAD SURGERY.

Under date of April 1 Lieut-Col. Nelson Miles Black, M. C., U. S. Army, was designated as officer in charge of the section of head surgery, Surgeon-General's Office, vice Col. Walter R. Parker.

NEW SENIOR CONSULTANT IN NEUROPSYCHIATRY FOR A. E. F.

Lieut.-Col. E. G. Zabriskie of New York City has been designated senior consultant in neuropsychiatry for the American Expeditionary Forces, succeeding Col. Thomas W. Salmon, who has returned to the United States for duty in the Surgeon-General's Office. Lieutenant-Colonel Zabriskie went to France as divisional neuropsychiatrist of the fourth division. Subsequently he was consultant in neuropsychiatry to the third and fifth corps and the first army. After the armistice he served as consulting neuropsychiatrist to the Savenay hospital center.

BONUS FOR DISCHARGED SERVICE MEN AND NURSES.

The Red Cross is trying to spread the information regarding the provisions of the new Revenue Bill for a $60 bonus to be paid to all soldiers and nurses discharged since April 1, 1917.

As many soldiers were discharged prior to the passage of the bill, the War Department is anxious that information regarding the bonus should be disseminated as widely as possible. Those who are discharged hereafter will receive this bonus on the same roll or voucher upon which they are paid their final pay.

Employers, editors and all persons in a position to give this information are asked to co-operate with the War Department in reaching all discharged men and nurses. Red Cross chapters, branches and auxiliaries are requested to post notices in prominent places.

RED CROSS FOR PREVENTIVE MEDICINE.

Fifteen of America's leading health specialists, acting with the distinguished physicians and scientists of Eng-

land, France, Japan and Italy, have affixed their names to a resolution of great import to the future welfare of mankind just adopted by the Inter-Allied Red Cross Conference in session at Cannes, France. The resolution, telling of the purpose "to spread the light of science and the warmth of human sympathy into every corner of the world," was adopted by the committee of Red Cross leaders which is preparing the program for world betterment to be submitted to the congress of Red Cross societies at Geneva thirty days after peace has been declared. The text of the resolution follows:

"We are assembled at the invitation of the Committee of Red Cross Societies to assist in the task for which that committee was constituted, namely: 'To formulate and propose to the Red Cross Societies of the world an extended program of Red Cross activities in the interest of humanity.'

"In addressing ourselves to this task, we desire to express our belief that while every measure should be taken to repair the ravages of war and to prevent all wars, it is no less important that the world should address itself to the prevention and amelioration of those ever present tragedies of unnecessary sickness and death which occur in the homes of all peoples.

"The world-wide prevalence of disease and suffering is in considerable measure due to causes which science has not yet disclosed, but a great part of it is due to widespread ignorance and lack of application of well-established facts and methods capable either of largely restricting disease or of preventing it altogether.

"It is clear that it is most important to the future progress and security of civilization that intelligent steps be taken to instruct the peoples of the world in the observance of those principles and practices which will contribute to their health and welfare.

"In the accomplishment of these great aims it is of supreme consequence that the results of the studies and researches of science should be made available to the whole world; that high standards of practice and proficiency in the prevention of disease and prevention of health should be promoted and supported by an intelligent and educated public opinion; and that effective measures should be taken in every country to secure the utmost co-operation between the people at large and all well directed agencies engaged in the promotion of health.

"We have carefully considered the general purposes of the committee of Red Cross Societies whereby it is proposed to utilize a central organization which shall stimulate and co-ordinate the voluntary efforts of the peoples of the world through their respective Red Cross societies; which shall assist in promoting the development of sound measures for public health and sanitation, the welfare of children and mothers. the education and training of nurses, the control of tuberculosis. venereal diseases, malaria and other infectious and preventable diseases, and which shall endeavor to spread the light of science and the warmth of human sympathy into every corner of the world, and shall invoke in behalf of the broadest humanity not alone the results of science but the daily efforts of men and women of every country, every religion and every race.

"We believe that the plans now being developed should at the earliest practical moment be put into effect and placed at the disposal of the world. In no way can this be done so effectively as through the agency of the Red Cross, hitherto largely representing a movement for ameliorating the conditions of war but now surrounded by a new sentiment and the wide support and confidence of the peoples of the world and equipping it to promote effective measures for human betterment under conditions of peace.

"We are confident that this movement, assured as it is at the outset of the moral support of civilization, has in it great possibilities of adding immeasurably to the happiness and welfare of mankind."

WAR NOTES

Dr. Andrew H. Frankel, who left his practice as a physician three days after America entered the war to enlist in the medical department of the navy, has returned to Milwaukee.

Captain Earling Ravn of Merrill has recently been home on a short furlough. Captain Ravn enlisted in the medical corps in May 1917, and received a commission as first lieutenant. He was sent to France almost immediately and has been there continuously, stationed in a hospital directly behind the lines. He received his commission as captain after he had been in the service only a short time.

Major G. I. Hogue of Milwaukee has been promoted to the rank of lieutenant-colonel and has been placed in command of an eye, ear, nose, and throat hospital in Paris, this having been his special work before enlisting.

Captain J. G. Hoffman of Hartford recently arrived home from service in France. Captain Hoffman enlisted early in the war, but owing to ill health, did not reach France until May 12, 1918, and was at once assigned to a French evacuation hospital at Sens. From there he was assigned to the 30th Division which he joined at Camp Couquidian in Brittany. Two weeks after the armistice, the 30th went to Luxemburg as a part of the army of occupation and spent Christmas and New Years on the Moselle. After four weeks in that section, the division was ordered home, leaving March 8 for home and arriving at Newport News March 19.

Dr. Roy Leutsker of Antigo has been promoted to the rank of Lieutenant, Senior Grade. He is stationed in one of the naval hospitals at the Great Lakes Naval Training Station.

Captain R. E. Davies has returned home from overseas and will resume his practice in Waukesha soon.

Dr. E. E. Tanner who has been practicing in Milwaukee for twenty-two years has left for Siberia. Dr. Tanner has been appointed a captain in the American army which is attached to the Czecho-Slovak army at Vladivostok and will serve with the American Red Cross.

Lieutenant C. C. DelMarcelle of Neenah was appointed assistant surgeon of the 3rd Army Corps, early in March. He has recently been decorated with the French Croix de Guerre for exceptional service at a first aid station in the Chateau Thierry fighting.

Psychological tests applied between April 27 and November 30, 1918, revealed a total of 45,653 men in the United States army under ten years "mental age." In other words, that number had minds of the average child of less than ten years of age. This somewhat startling fact was revealed by Major R. M. Yerkes, United States army, in an address before the National Academy of Science in Washington.

Major Clarence A. Baer, who recently returned to the United States after sixteen months of medical service with the Red Cross in Europe, was decorated with the Croix de Guerre with one star, the Medaille d'Honneur, and the Reconnaissance Francaise. He also received the Eagle of Poland from the Polish government.

Captain Arthur Mitten returned to his home in Milwaukee after several months service over-seas. Captain Mitten, who was attached to the ambulance company of the 125th Regiment, spent nearly three months in German prison camps.

Captain John S. Foat, who has been home in Ripon on a furlough, returned to Fort Sheridan, Illinois, where he expects to soon receive his discharge.

Captain Gerhard A. Bading, former health commissioner and mayor of Milwaukee, who entered service as a first lieutenant shortly after war was declared, is now serving in northern China.

Lieutenant W. J. Thomson of Portage has been promoted to the rank of captain. Dr. Thomson entered the service on January 13, 1918, and upon arrival in France was transferred from the Aero Casual camp as surgeon of the 312th Infirmary company. He recently met with an auto accident and is at present recuperating from his injuries, in the southern part of France.

Captain Clifton A. Cooper of Norwalk has been promoted to the position of chief diagnostician of the 7000 bed hospital at Brest, France, where he has been located since June, 1918.

Dr. Edward L. Jenkinson of Rhinelander has been promoted to the rank of captain, according to a letter received by his parents. Captain Jenkinson is still doing X-ray work at Evacuation Hospital 49, Coblenz, Germany.

Dr. J. A. Opstedal of Madison who has just been released from active duty with the U. S. N. Reserve Force and was stationed at the Naval Hospital, Pelham Bay Park, New York, has been visiting friends around De Forest.

Dr. Frank Bennett of Waterford has opened an office for the practice of his profession in Burlington. Dr. Bennett has just returned to civilian life after thirteen months service as captain in the medical corps, being assistant chief of the medical service at the base hospital at Camp Hancock, Georgia.

Dr. Robert L. Zaegel of Sheboygan has recently received a promotion from lieutenant to captain, and is now stationed at Port du Mausson, near Metz. Before entering the service, Captain Zaegel acted as interne in the Denver city and county hospital.

An organization of men who saw active service has been launched in Superior which will be known as the Superior Medical Officers of the World's War. Dr. W. A. McEachern was elected president; Dr. C. W. Giesen, vice-president; and Dr. W. E. Hatch, secretary and treasurer. Only physicians who saw active service are eligible for membership.

Dr. L. H. Flynn of Eau Claire has returned from service and will resume his former practice.

Lieutenant Neil F. Crowe of Antigo, formerly with the British military medical corps but who is now stationed at the Base Hospital, Camp Grant, has been promoted to the rank of captain. Doctor Crowe arrived in New York March 6 on the Mauretania and has been stationed at Camp Grant since March 21.

All nurses returning from military service may apply for public health nursing scholarships beginning May 1 in Chicago and June 1 in Ann Arbor. The Milwaukee committee on nursing activities hopes to have Milwaukee nurses take these courses. The national Red Cross has appropriated $75,000 to be used in scholarships, besides requesting that each chapter furnish nurses in their community with scholarships from the chapter funds and place them in the field under the chapter's jurisdiction. The idea is to furnish every county with a well-qualified health nurse.

Dr. H. H. Ainsworth, of Madison, now with the army of occupation in Coblenz, Germany, is spending a furlough in England, the guest of relatives and friends in London and Manchester. Capt. Ainsworth is chief of organization in eye service.

Milwaukee chapter, American Red Cross, is ready to furnish complete lists of trained nurses, practical nurses and midwives to physicians and institutions. The list was obtained through the survey of nursing resources which has just been completed. Those desiring lists may apply at the Red Cross office, Gross building.

ORDERS TO OFFICERS OF THE MEDICAL CORPS, U. S. ARMY.

To Camp John Wise, Texas, from San Antonio, Capt. J. H. Fowler, Lancaster.

To Fort D. A. Russell, Wyo., as tuberculosis examiner, from Camp Lewis, Capt. H. M. Coleman, Barron.

To Fort Des Moines, Iowa, from Camp Pike, Lieut. C. B. Hake, Milwaukee.

To Fort Ontario, N. Y., from Danville, Capt. W. T. Kradwell, Wauwatosa.

To Fort Snelling, Minn., from Camp Hancock, Lieut. J. H. Carroll, Milwaukee.

To Lake Charles, La., Gerstner Field, from Montgomery, Capt. H. S. Steenberg, Milwaukee.

To Rockefeller Institute for instruction in the treatment of infected wounds, and on completion to Walter Reed General Hospital, D. C., for instruction, and on completion to his proper station, from Colonia, Lieut. H. E. Bundy, Milwaukee.

To St. Louis, Mo., from Fort Des Moines, Lieut. A. Yaffe, Milwaukee.

To Camp Lee, Va., as orthopedic surgeon, from Fort Sheridan, Lieut. J. D. Gillis, Wauwatosa.

To Camp Sherman, Ohio, base hospital, from Camp Custer, Lieut. H. C. Saltzstein, Milwaukee.

To Fort Sheridan, Ill., from Camp Dix, Major R. Kaysen, Plymouth.

To Pittsburgh, Pa., from Camp Custer, Lieut. F. Nec, Spring Green.

To Camp Meade, Md., from Fairfield, Capt. E. G. Festerling, Reedsville.

To Fort Sheridan, Ill., from Fort Riley. Capt. W. A. McEachern, Superior.

To Walter Reed General Hospital, D. C., from Fort Ontario, Capt. W. T. Kradwell, Wauwatosa.

The following order has been revoked: To Lake Charles, La., from Montgomery, Ala., Capt. H. S. Steenberg, Milwaukee.

HONORABLE DISCHARGES, MEDICAL CORPS, U. S. ARMY.

J. E. Hearty, Bloomington.
A. S. Parker, Clinton.
C. O. Decker, Crandon.
L. H. Flynn, Eau Claire.
A. L. Kyllo, Grantsburg.
A. DePierre, Green Bay.
M. E. Rideout, Hortonville.
J. C. Brewer, Jefferson.
R. R. Heim, Marinette.
G. M. Fitzgerald, Milwaukee.
C. B. Hake, Milwaukee.
W. L. Herner, Milwaukee
W. T. McNaughton, Milwaukee.
U. Senn, Milwaukee.
W. A. Sickels, Milwaukee.
E. A. Smith, Milwaukee.
J. W. Smith, Milwaukee.
C. E. Stolz, Milwaukee.
E. L. Tharinger, Milwaukee.
A. J. Berger, New Holstein.
F. Brockway, Oshkosh.
O. A. Nelson, Park Falls.
J. E. Rueth, Sun Prairie.
G. H. Reddick, Wabeno.
J. F. Bennett, Wauwatosa.
J. B. Thompson, Wittenberg.
C. C. Post, Barron.
H. M. Helm, Beloit.
J. H. Prill, Chetek.
W. M. Johnson, Dale.
A. T. Shearer, Edgerton.
C. C. Vogel, Elroy.
F. A. Boeckmann, Greenwood.
G. E. Eck, Lake Mills.
W. Campbell, Menomonee Falls.
W. B. Ackermann, Milwaukee.
A. A. Mitten, Milwaukee.
G. E. Seaman, Milwaukee.
J. W. Bird, Stevens Point.
L. H. A. Nowack, Watertown.
F. W. Aplin, Waukesha.
A. H. Frankel, Milwaukee.
J. J. Horwitz, Milwaukee.
K. T. Meyer, Brillion.
D. G. Hugo, Chilton.
A. L. Myrick, Eastman.
F. P. Neis, Gilman.
R. L. Cowles, Green Bay.
F. L. Crikelair, Green Bay.
F. H. Kennedy, Greenwood.
G. C. Waufle, Janesville.
J. Rosholt, La Crosse.
E. H. Townsend, La Crosse.
W. S. Middleton, Madison.
T. H. Burback, Milwaukee.
C. J. Corcoran, Milwaukee.
O. H. Foerster, Milwaukee.
O. R. Lillie, Milwaukee.
P. J. Merten, Milwaukee.
S. R. Mitchell, Milwaukee.
J. P. Schlaikowski, Milwaukee.
L. G. Sykes, Milwaukee.
E. A. Ketterer, Montfort.
J. M. Conley, Oshkosh.
V. Droock, Rice Lake.
H. McCarthy, Richland Center.
R. K. Lohmiller, Superior.
C. J. Rollefson, Superior.
T. G. Parker, Union Grove.
G. W. Curless, Walworth.
E. E. Fleming, Wausau.
G. A. Thielke, Wausau.
E. J. Mitchell, Brodhead.
H. B. Beeson, Cornell.
A. D. Smith, Gilmanton.
I. E. Levitas, Green Bay.
P. C. Hodges, Madison.
R. C. Brown, Milwaukee.
C. A. Evans, Milwaukee.
H. B. Hitz, Milwaukee.
O. E. Lademan, Milwaukee.
F. B. McMahon, Milwaukee.
F. A. Thompson, Milwaukee.
F. W. Pope, Racine.
W. L. Stephenson, Ladysmith.
E. E. Haggerty, La Farge.
R. Drane, Madison.
C. W. Lockhart, Mellen.
W. W. Coon, Milton Junction.
R. J. Bach, Milwaukee.
H. B. Podlasky, Milwaukee.

THE STATE MEDICAL SOCIETY OF WISCONSIN

ORGANIZED 1841

Officers 1919

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J. S. KEECH, Racine, 1st Vice President
L. A. POTTER, Superior, 2nd Vice President

HERMAN GILBERT, Madison, 3rd Vice President
ROCK SLEYSTER, Wauwatosa, Secretary

DANIEL HOPKINSON, Milwaukee, Ass't Secretary
S. S. HALL, Ripon, Treasurer

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2nd Dist., G. Windesheim - Kenosha

TERM EXPIRES 1924
3rd Dist., F. T. Nye - Beloit
4th Dist., W. Cunningham - Platteville

TERM EXPIRES 1919
5th Dist., W. F. Zierath - Sheboygan
6th Dist., H. W. Abraham - Appleton

TERM EXPIRES 1920
7th Dist., Edward Evans - LaCrosse
8th Dist., T. J. Redelings - Marinette

TERM EXPIRES 1921
9th Dist., Joseph Smith - Wausau
10th Dist., R. U. Cairns - River Falls

TERM EXPIRES 1922
11th Dist., J. M. Dodd - Ashland
12th Dist., Hoyt E. Dearholt - Milwaukee

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ROCK SLEYSTER, Wauwatosa
C. H. LEMON, Milwaukee

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The Wisconsin Medical Journal, Official Publication

LIST OF EXECUTIVE OFFICERS OF COUNTY MEDICAL SOCIETIES.

County.	President.	Secretary.
Ashland-Bayfield-Iron	J. V. Wenzel, Ashland	C. J. Smiles, Ashland.
Barron-Polk-Washburn-Sawyer-Burnett	I. G. Babcock, Cumberland	D. L. Dawson, Rice Lake.
Brown-Kewaunee	D. F. Gosin, Green Bay	E. S. McNevins, Green Bay.
Calumet	H. C. Krohn, New Holstein	F. P. Knauf, Kiel.
Chippewa	S. E. Williams, Chippewa Falls	F. T. McHugh, Chippewa Falls.
Clark	H. H. Christofferson, Colby	E. L. Bradbury, Neillsville.
Columbia	O. O. Force, Pardeeville	A. F. Schmeling, Columbus.
Crawford	C. B. Lumsford, Gays Mills	A. J. McDowell, Soldiers Grove.
Dane	W. H. Sheldon, Madison	H. P. Greeley, Madison.
Dodge	F. T. Clark, Waupun	A. E. Bachhuber, Mayville.
Door	H. C. Sibree, Sturgeon Bay	T. C. Proctor, Sturgeon Bay.
Douglas	A. J. Hovde, Superior	John Baird, Superior.
Dunn-Pepin	W. H. Parks, Glenwood	N. L. Howison, Menomonie.
Eau Claire	E. M. A. Sizer, Eau Claire	R. E. Mitchell, Eau Claire.
Fond du Lac	C. W. Leonnard, Fond du Lac	D. N. Walters, Fond du Lac.
Grant	M. B. Glasier, Bloomington	J. C. Betz, Boscobel.
Green	W. B. Gnagi, Monroe	W. B. Monroe, Monroe.
Green Lake-Washara-Adams	G. E. Baldwin, Green Lake	A. J. Wiesender, Berlin.
Iowa	H. D. Ludden, Mineral Point	J. R. Hughes, Dodgeville.
Jefferson	R. C. Morris, Ft. Atkinson	W. A. Engsberg, Lake Mills.
Juneau	E. H. Townsend, New London	A. T. Gregory, Elroy.
Kenosha	T. W. Ashley, Kenosha	J. F. Hastings, Kenosha.
La Crosse	H. E. Wolf, La Crosse	Sara Nimocks, La Crosse.
La Fayette	J. C. Hubenthal, Belmont	H. O. Shockley, Darlington.
Langlade	E. J. Donohue, Antigo	J. C. Wright, Antigo.
Lincoln	H. G. Hinckley, Merrill	D. B. Reinhart, Merrill.
Manitowoc	W. G. Kemper, Manitowoc	J. E. Meany, Manitowoc.
Marathon	A. B. Rosenberry, Wausau	F. H. Frey, Wausau.
Marinette-Florence	J. W. Boren, Marinette	Luella E. Axtell, Marinette.
Milwaukee	G. J. Kaumheimer, Milwaukee	Dan. Hopkinson, Milwaukee.
Monroe	S. D. Beebe, Sparta	T. J. Sheehy, Tomah.
Oconto	C. W. Stoelting, Oconto	Minnie Hopkins, Oconto.
Oneida-Forest-Vilas	W. C. Bennett, Rhinelander	F. R. Boyer, Rhinelander.
Outagamie	M. J. Sandborn, Appleton	G. T. Hegner, Appleton.
Ozaukee	G. F. Savage, Port Washington	H. M. Katz, Cedarburg.
Pierce	W. A. Lumley, Ellsworth	Rollo Cairns, River Falls.
Portage	J. D. Lindores, Stevens Point	F. A. Marrs, Stevens Point.
Price-Taylor	G. H. McClure, Westboro	G. C. Wichman, Rib Lake.
Racine	J. G. Meachem, Racine	Susan Jones, Racine.
Richland	R. H. Delap, Richland Center	G. Benson, Richland Center.
Rock	W. A. Munn, Janesville	E. B. Brown, Beloit.
Rusk	W. F. O'Connor, Ladysmith	L. M. Lundmark, Ladysmith.
Sauk	F. D. Hulburt, Reedsburg	Roger Cahoon, Baraboo.
Shawano	A. J. Gates, Tigerton	W. H. Cantwell, Shawano.
Sheboygan	Edmund Knauf, Sheboygan	Harry Heiden, Sheboygan.
St. Croix	B. Kunny, Baldwin	O. H. Epley, New Richmond.
Trempealeau-Jackson-Buffalo	E. A. MacCornack, Whitehall	C. F. Peterson, Independence.
Vernon	J. K. Schreiner, Westby	F. E. Morley, Viroqua.
Walworth	M. D. Cottingham, Lake Geneva	E. Kinne, Elkhorn.
Washington	H. F. Weber, Newburg	A. H. Heldner, West Bend.
Waukesha	J. H. Overbaugh, Hartland	S. B. Ackley, Oconomowoc.
Wanpaca	Fremont Chandler, Wanpaca	G. T. Dawley, New London.
Winnebago	F. G. Connell, Oshkosh	H. W. Morgenroth, Oshkosh.
Wood	J. C. Hayward, Marshfield	Wm. Hipke, Marshfield.

SOCIETY PROCEEDINGS

EAU CLAIRE COUNTY.

The regular monthly meeting of the Eau Claire County Medical Society was held Monday, March 31, 1919, following a supper at the Galloway Hotel. The following program was given: "Focal Infections in Relation to the Eye," by Dr. F. S. Cook; and "An Informal Talk" by Dr. Valentine A. Gudex.

R. E. MITCHELL, M. D., *Secretary.*

A meeting of the Eau Claire Medical Society was held at the Galloway Hotel, Monday, April 28. Dr. L. H. Flynn gave a talk on "Army Experiences", and a general discussion on hospital reorganization was held. Supper was served at 7:15 P. M.

R. E. MITCHELL, M. D., *Secretary.*

CHIPPEWA COUNTY

The Chippewa County Medical Society held its regular meeting April 11, 1919, at the club rooms of the Edward Rutledge building. The meeting was opened with a banquet, after which matters concerning public health and the present fight on tuberculosis now being waged in Chippewa Falls, were discussed by different speakers. Dr. S. E. Williams, president of the society, presided.

F. T. MCHUGH, M. D., *Secretary.*

FOND DU LAC COUNTY

The regular monthly meeting of the Fond du Lac County Medical Society was held at the Palmer House at 8:30 P. M., April 9, 1919. A very interesting paper on "Caesarian Section" was read by Dr. D. J. Twohig, followed by a discussion by Dr. F. S. Wiley. Important business matters were then taken up, after which a smoker was held.

At the next regular monthly meeting which will be held May 14, 1919, Dr. G. V. Mears will give an account of his obstetrical experience obtained in the past thirty years.

D. N. WALTERS, M. D., *Secretary.*

KENOSHA COUNTY

At the regular monthly meeting of the Kenosha County Medical Society held April 17 at the Elks Club, Dr. L. M. Warfield of Milwaukee gave a very interesting address on the subject of "General Infections". The speaker brought valuable information gleaned from his army service and general practice in city hospitals. The meeting was well attended and was followed by a luncheon in the private dining room of the club.

J. F. HASTINGS, M. D., *Secretary.*

MARINETTE-FLORENCE COUNTY.

Owing to extra burdens carried by our members on account of war conditions, no meeting of the Marinette-Florence County Medical Society was held in Marinette for one year. During the interim, there was one joint meeting with the Menomonie society in Menomonie. On March 28, 1919, the society again convened, meeting being held at the home of Dr. Bird. All the city members but two were present and this number was augmented by two Menomonie members.

The application of Dr. J. Gomber, Goodman, for admission to membership of the society was presented and submitted to the censors. He was recommended for membership and his application voted upon affirmatively by the society. The annual report of the treasurer followed and was accepted.

The election of officers resulted as follows: President, Dr. J. W. Boren; Vice -president, Dr. A. T. Nadeau; Secretary and Treasurer, Dr. Luella E. Axtell; Delegate, E. E. Axtell; Alternate, Dr. H. F. Schroeder; Censor, Dr. T. A. Lid.

A formal vote of thanks was tendered the secretary and treasurer, Dr. Luella Axtell, for her services, and ordered to be spread upon the minutes.

The evening's program consisted of informal discussions. The subjects were "Graves' Disease," introduced by Dr. Luella Axtell, with a series of extracts from recent magazine articles; and "Influenza," introduced by Dr. Bird with an original article. The discussion was animated, general and profitable.

Following the program, a social time was enjoyed and plans informally talked over as to future programs and the resumption of meetings. Decision was left to the future and a meeting was arranged for the officers with those of the Menomonie society to make plans and find out if lectures can be secured from Madison and Marquette Universities.

LUELLA E. AXTELL, M. D., *Secretary.*

MILWAUKEE MEDICAL SOCIETY

The Milwaukee Medical Society held its regular monthly meeting in their rooms in the Colby-Abbott Building, Tuesday, April 8, 1919, at 8 P. M. The membership applications of Drs. F. B. McMahon, A. J. Seeger, C. W. Morter, and R. E. Morter were favorably acted upon.

The evening was devoted to a short review of the work of Base Hospital 22, presented by various members of the unit. The following program was given: "Surgery at Base Hospital 22," C. A. Evans, L. C., M. C., A. E. F.; "The Army Sanitary Schools at Langres," R. C. Brown, L. C., M. C., A. E. F.; "Medical Aspects on Base Hospital Work," W. J. Egan, C. M. C., A. E. F.; and "Laboratory Work at the Hospital," E. L. Tharinger, L. M. C., A. E. F.

An informal discussion followed, led by Capt. H. B. Hitz, Lieut.-Col. F. A. Thompson, Capt. E. A. Smith, Lieut. O. R. Little, and others.

OSCAR LOTZ, M. D., *Secretary.*

A meeting of the Milwaukee Medical Society was held in the Gold Room of the Hotel Wisconsin, April 21, 1919, at 8:30 P. M. The distinguished French Surgeon, Dr.

G. Dehelly, who is co-editor with Dr. Carrel of the publication, "The Treatment of Infectious Wounds," detailing the Dakin-Carrel method as employed in military and civil practice, and who is now associated with Dr. Carrel at the Rockefeller Institute for Medical Research, addressed the meeting.

OSCAR LOTZ, M. D., *Secretary.*

MILWAUKEE COUNTY MEDICAL SOCIETY.

A meeting of the Milwaukee County Medical Society was held April 11, 1919, at the Wisconsin Hotel. The program consisted of a paper by Drs. W. C. F. Witte and J. E. Royer on "A Report on a Case of Spinal Cord Tumor," and a paper by Dr. F. Gaenslen on "Chronic Lesions of the Hip Joint." Dr. M. N. Federspiel made a statement giving general observations concerning the relationship between diseased teeth and ill health, errors in diagnosis, and methods of eradication and treatment. The meeting was largely attended.

DANIEL HOPKINSON, M. D., *Secretary.*

ROCK COUNTY

The Rock County Medical Society met at the Y. M. C. A. at seven P. M., April 29, for its regular monthly dinner. Dr. Wm. S. Middleton of the University of Wisconsin told of his experiences as a medical officer in France. Clinical meetings are being planned for June and September and some worth while get-together meetings for the summer months.

E. B. BROWN, M. D., *Secretary.*

WOOD COUNTY.

A meeting of the Wood County Medical Society was held at Marshfield, Wednesday, April 23, 1919. The following program was presented: "Influenza-Pneumonia," Dr. C. E. Meyers, discussion led by Dr. Edw. Hougen; "Eclampsia," by Dr. Hugh Waters, with discussion led by Dr. K. W. Doege, and "Hydrocephalus," by Dr. V. A. Mason, with discussion opened by Dr. J. C. Hayward.

WM. HIPKE, M. D., *Secretary.*

WINNEBAGO-OUTAGAMIE COUNTY.

A joint meeting of the Winnebago and Outagamie County Medical Societies was held April 30, at 6:00 P. M., at the Valley Inn, Neenah. The meeting was opened with a supper, after which Dr. Jos. Brenneman of Chicago gave an interesting talk on "The Practical Feeding of Babies". Dr. Herman Kretchmer of Chicago also addressed the meeting on "Prostate, the Surgical Treatment". Sixty members of the two societies were present.

H. W. MORGENROTH, M. D., *Secretary.*

CORRESPONDENCE

Marinette, Wis., April 11, 1919.

Dr. Rock Sleyster,
Wauwatosa, Wis.

Dear Doctor:

I wonder if you will be at all interested in the enclosed. To me it seems vastly more worth printing than minutes. This patent medicine firm came out with a flaring ad., announcing free consultations while their representative did not even lay claim to the much abused title of "doctor".

The result was that advertisements were withdrawn and the concern discontinued business. As this concern is doing business all over the country I should think other medical societies might follow the example of our enterprising and energetic president and much good result.

The ad. begins "SPECIALIST ON GOITER" and though there is no specific statement that these "specialists" are Physicians the wording is such that it is evident that such meaning is intended to be conveyed.

Perhaps, probably, you know more about this than I can tell you but it seemed well to give you our experience and leave it to you as to whether or not it will be of any value to others.

Very sincerely,

LUELLA E. AXTELL.

Apr. 11, 1919.

Mr. V. A. Lundgren, Druggist,
Marinette, Wis.

Dear Sir:

My attention as President of the Marinette-Florence Co. Medical Society, has been called to the Warner Goiter Cure representatives' activities in Marinette, selling their products through your stores. You know the friendly interest the medical profession of Marinette has always taken in your stores and we feel justified in issuing friendly warning that these activities must cease, otherwise legal steps will be taken.

Yours truly,

J. W. BOREN,
Pres. Marinette-Flor. Co. Med. Soc.

Oshkosh, Wisconsin,
May 3, 1919.

Dr. Rock Sleyster,
Wauwatosa, Wisconsin.

Dear Doctor:

Enclosed find letter received from Dr. Drueck and answer I sent him.

At our meeting there was a resolution passed that if satisfactory to the editor of the State Medical Journal, we should like to have both letters and answers published.

Very truly yours,

H. W. MORGENROTH.

Chicago, Illinois,
March 24, 1919.

Winnebago County Medical Society,
Dr. H. W. Morgenroth, Secretary,
Oshkosh, Wisconsin.

Dear Doctor Morgenroth:

If your society defrays the traveling expenses of visiting speakers, I should like to present a paper on "Rectal Surgery Under Local Anesthesia".

Very truly,

CHARLES J. DRUECK.

Oshkosh, Wisconsin,
May 2, 1919.

Dr. Chas. J. Drueck,
Chicago, Illinois.

Dear Doctor:

In reply to your communication of March 24th, will say that it has been customary in the Winnebago County Society and we were of the opinion that in other regular Medical Societies, for the Society to invite guests to speak before them.

Very truly yours,

H. W. MORGENROTH.

ASSOCIATION NEWS

NATIONAL CONFERENCE OF SOCIAL WORK.

The claim of public health enthusiasts that questions of physical well being affect every other department of life, finds unusual exemplification in the program of the National Conference of Social Work. This organization will hold its forty-sixth annual meeting at Atlantic City, June 1-8. The extensive outline of the week's meeting has just been issued from the permanent office of the Conference at 315 Plymouth Court, Chicago. Miss Julia C. Lathrop, chief of the Federal Children's Bureau, is president of the Conference.

"Health and the Standard of Living" has been selected as the general theme of the Conference division on health. Dr. C. E. A. Winslow of Yale University, the chairman of this division, has arranged for a symposium on the relationship of sickness and poverty. The speakers will be Karl DeSchweinitz of Philadelphia, Royal Meeker of Washington and Edward T. Devine of New York. Seven applications of the general theme, health and standard of living, will be successively presented under Dr. Winslow's leadership. Each will be the topic of a sectional meeting. These topics are: housing, the family food supply, tuberculosis, medical and nursing care, infant mortality, industrial hazards, and venereal disease.

Dr. William H. Welch of Baltimore and Dr. L. Emmett Holt of New York will participate in a discussion of the new health program for children of school age. This is one of several discussions that are scheduled to occur under the auspices of other divisions than the one on health. Among such topics may be noted: illegitimacy, the day nursery, the girl problem, public aid to mothers, the handicapped soldier, state care of mental diseases, and health insurance.

More than 4,000 delegates are expected to attend the Atlantic City meeting. Unusual emphasis upon health problems will be natural in view of the fact that the American Medical Association is scheduled to meet in the same city the week following. The more important discussions of the National Conference of Social Work from the standpoint of physicians and other public health workers are expected to occur the latter part of the week, for the convenience of those who come early to the meeting of the American Medical Association.

NEWS ITEMS AND PERSONALS.

Lieutenant Colonel Gustavus I. Hogue, Milwaukee, has been placed in charge of the Optical Division of the American Expeditionary Forces with headquarters at Paris.

Milwaukee County will take a new and extensive step in the near future toward the protection of Milwaukee's health in the establishment of a general clinic in the downtown district. An appropriation of $40,000 has been recommended to meet the initial cost of opening the new station. It is planned to accustom the public to availing itself of facilities to be offered by the medical station, so that when the new county hospital is erected at Twenty-fifth street and Grand avenue, persons in need of attention will come there.

The Sisters of St. Dominie who are in charge of St. Catherine's Hospital, Kenosha, have closed an option on the Pennoyer Sanatorium and will use their present quarters as a training school for nurses and the sanatorium as a moderate price hospital.

The Physicians' and Surgeon's Adjusting Association of Kansas City wishes to call the attention of physicians in this field to the fact that they do collect old accounts. This Journal has accepted their advertisement, which will be found on another page of this issue, and any business transacted with this company will no doubt be entirely satisfactory to those who have dealings with them.

The bill amending the compensation act so as to give injured workmen the choice of electing Christian Science treatment passed the Senate, 24 to 7. If this bill is enacted into law, the Christian Science treatments must be paid for by the employer or the insurance company. Heretofore, the Christian Scientist when electing scientist treatment has had to pay his own fees.

The state legislature has adopted an amendment to the statutes of Wisconsin giving counties, having a population of fifty thousand or more, authority to erect, establish and maintain isolation hospitals or places for the care and treatment of all persons who are

required to be cared for and treated at the expense of the county or the various towns in the county.

Dr. Frank Bennett who recently returned from service, has opened an office in Burlington.

Marquette University has remodeled the former home of William Plankinton and equipped it as a modern and thoroughly up-to-date hospital. It will be known as the Trinity Hospital annex and will be able to care for forty-two patients at a time, thus affording a much needed and very considerable addition to the 106 beds at Trinity. It is proposed to make the annex a special hospital for the treatment of eye, ear, nose and throat cases; convalescent accident cases will also be transferred there from Trinity in order that they may recuperate out of doors in the beautiful grounds that surround the old home.

Sister M. Eulalia, who has been in charge of St. Mary's Hospital, Madison, for the past three years has been recalled to St. Louis. Sister M. Liberata, her assistant, will succeed Mother Columba, the newly appointed superintendent of St. Mary's.

Plans for floating the loan to cover the cost of building the four-story addition to Mercy Hospital, Janesville, were discussed at a recent meeting of the board of directors.

Fifty-eight patients from the home for the feeble-minded at Chippewa Falls have been transferred to the Southern Wisconsin home for the feeble-minded at Union Grove. This transfer marks the opening of a new state institution which has been under erection for the past four years.

Doctor and Mrs. P. H. Jobse have returned to Milwaukee from Wilsonville, Oregon, and the doctor will resume his business associations with Doctor W. C. F. Witte.

Plans for the proposed new isolation hospital in Superior are nearing completion and the commission expects to select a site and order the work at an early date, to relieve the unbearable conditions existing at the old hospital on the Dean tract.

Ten American army nurses have been awarded the Medaille de Honneur des Epidemics by the French government, the American Red Cross headquarters have been advised. Among those honored was Agnes W. Reid of La Crosse.

Plans for the proposed Milwaukee county hospital indicate that Milwaukee county will not only build one of the most modern institutions of this kind, but that it will rank with the largest in this country. The plans provide for a building nine stories high with sufficient space to house over a thousand patients and will cost in the neighborhood of $1,800,000. The hospital is to be located on the Schandein property at Grand Avenue and Twenty-fifth street.

The U. S. Government will shortly open the Resthaven Sanitarium at Waukesha, Wisconsin, as a hospital. This hospital is to be used to treat discharged soldiers suffering with nervous diseases. It will be managed by the U. S. Public Health Service in connection with the work of the Bureau of War Risk Insurance.

Physicians skilled in the diagnosis and treatment of nervous diseases will be commissioned as assistant surgeons or past assistant surgeons, in the Reserve Corps of the U. S. Public Health Service, for duty at Waukesha.

The pay of the two grades is $2000.00 and $2400.00 yearly. Quarters or commutation for quarters is also allowed. For further particulars or information apply to Passed Assistant Surgeon, Lawrence Kolb, U. S. Public Health Service, Waukesha, Wisconsin.

Dr. T. W. Ashley of Kenosha has left for post-graduate work in New York and Cleveland, where he will take special work in the treatment of goiter, under Dr. G. W. Crile. During Dr. Ashley's absence, his practice will be in charge of Dr. O. T. Allen of the Chicago Eye, Ear, Nose and Throat Hospital.

The St. Mary's Hospital at Sparta is to be have extensive additions, the work of which is already under way.

A fifty year ban has been placed by the Iowa State Medical Society on the purchase of medical implements or appliances or other things made in Germany. At the society's convention recently, a pledge was given that such purchase by any member during the next fifty years shall be considered evidence of pro-Germanism.

One hundred scales donated by the Red Cross have been sent to the largest public and parochial schools in Milwaukee to start a new campaign for prevention of sickness among the children, probably the first of its kind in the country. Every child is to be weighed and measured.

Plans are being formulated for remodeling the famous Resthaven Hotel at Waukesha, which has recently been acquired by the government, into a hospital. According to tentative plans announced by the war department, 300 patients will be accommodated at Resthaven. The patients will include disabled soldiers, sailors, and marines.

Doctor Nutt, who spent the past two years at Manitowoc where he established a successful medical practice, has returned to Plymouth and will again be in charge of the Moraine Gravel Company.

One of the most important provisions in the University appropriation bill recently passed relates to the establishment of a four year medical course. The University authorities will not form plans for the course without a year or two of study. The bill removes legislative restrictions.

Marathon County is not to build an isolation hospital. The county board killed the project by the decisive vote of 49 to 8, and it is probably buried for all time.

Dr. H. A. Jefferson has opened an office in Clintonville where he will begin the practice of his profession.

Dr. Chas. A. Wright has purchased the Rice Sanitarium in Delavan and will take possession of the same in the near future. The name of the institution will be changed to the Delavan Sanitarium.

The need of a contagious hospital for Eau Claire to accommodate patients not only from the city but from the county as well was one of the most important matters discussed at the regular meeting of the board of directors of the Civic & Commerce Association, recently. Dr. E. L. Mason, one of the directors, reported that the Eau Claire County Medical Society had appointed a special committee to investigate the matter and to report thereon at the next meeting. No action was taken in the matter, pending the investigation and report of the committee of the medical society.

Although the completion of a government inquiry throughout the United States reveals an increase in the use of drugs and the number of those addicted, contrary conditions are found in Milwaukee and the surrounding district, according to Paul A. Hemmy, collector of internal revenue. Mr. Hemmy stated that from reports of the inspectors, it was shown that the amount of narcotics used in this district has decreased greatly in the last year and that it is safely estimated that thirty per cent less of opiates and narcotics has been used during that period. Mr. Hemmy stated that this is being brought about by the close and efficient work of the physicians in their co-operation with the government in helping wipe out this evil.

Dr. Bertha V. Thomson of Oshkosh, appointed by the commission council as city health commissioner, is the first woman ever appointed to that job and there are probably few women in the United States who can boast of a similar distinction.

Dr. V. D. Crone, eye, ear, nose and throat specialist of Peoria, Illinois, who has recently completed extensive post-graduate work in New York, has associated in business with Dr. F. T. Nye of Beloit.

The U. S. Public Health Service is putting forth the most strenuous efforts to lessen venereal disease, and is enlisting the assistance of all physicians and druggists. The various State Boards are co-operating most actively. The New York State Board of Health, for example, has established venereal clinics in the larger cities and towns and is conducting post-graduate courses in New York for the training of medical men to handle the work in these clinics. In the belief that the syphilis situation could be handled better if treatment for the general public were made possible, Col. H. A. Metz of the H. A. Metz Laboratories, New York, is offering to the government and to the institutions co-operating with the U. S. Public Health Service, Salvarsan and Neosalvarsan at practically cost. Believing, as he does, in humanitarianism in business, he has extended these same low prices to all state and municipal institutions treating the general public, so that there may be no further excuse why the poor should not get the benefit of the best methods in the treatment of syphilis.

Dr. R. C. Blankenship, who was recently mustered out of service, has started the practice of his profession in Stoughton.

The second anniversary of the opening of Rib View Sanatorium at Wausau was celebrated April 15.

The dental clinic at Fond du Lac, to care for the children of Fond du Lac who are unable to secure proper attention for their teeth, was opened Monday, April 21.

Dr. O. P. Schnetzky, who for the past six years has been located at Skyler, Nebraska, has moved to Princeton where he will engage in practice.

A bill has been introduced in the assembly to enable the state to take over and maintain all the county tuberculosis sanatoriums. The object of the bill is supposed to be economy in maintenance.

Dr. Stirn and Dr. Ketterer of Montfort have recently signed a contract whereby they become partners in the medical profession.

The Great Lakes naval training station will be exhibited in miniature form at the meeting of the National Medical association in Atlantic City in June, according to the Bulletin, official paper of the station. Models are being prepared of the two-story barrack buildings, dispensaries, sewage disposal plant, and other features of the station. The models, drawings and photographs will show the water, heat and lighting systems, which have contributed to the station's high record of health and sanitation. Commander Mink says the bureau of medicine and surgery will have a model showing the dispensary and sick bay arrangements on a modern battleship and maps showing the relative percentages of various diseases during certain periods of the year in all Naval units.

An emergency hospital is desired by Oshkosh physicians as shown by a petition presented to the commission council and signed by twenty-four doctors of the city. The desire is for a permanent institution where patients suffering from contagious diseases can be properly cared for. The matter was referred, but all of the commissioners are in favor of the plan and have been giving the matter attention. During the influenza epidemic a temporary emergency hospital was in use just north of the city, but its location was not convenient.

The Brown County Medical Society has pledged its support to the free dispensary project which welfare organizations propose to establish in Green Bay. This favorable action by the doctors practically insures the establishment of the dispensary.

The public school directors of Milwaukee have agreed to transfer school inspection work to the health department. The school board rules committee adopted this

resolution: "Resolved, That this committee report to the board that, providing suitable plans can be worked out with the common council and that the common council is willing to assume the responsibility for the maintenance and operation of the school hygiene department and will provide proper funds for such care and maintenance in the budget for 1920 and thereafter, that the board favor such transfer and that the president appoint a special committee of three to confer with a similar committee of the common council on the question."

Seizure proceedings were begun by the government to take possession of 7,200 bottles of Wilson's "anti-flue" solution, labeled as preventive and remedy for "flu," colds and grippe, which it is charged were shipped from Cincinnati to a Chicago wholesale drug concern in violation of the food and drug act.

DEATHS

Dr. A. F. Hahn died at his home in Eau Claire, Monday, April 21, at the age of fifty-one. He was born in Shell Rock, Iowa, and for twenty-one years had been a practicing physician in Eau Claire.

The death of Dr. Marcus W. Haskell, for many years a practicing physician in Richland Center, occurred at his home, April second. He was a few days over 67 years of age and was known to nearly every grown person in the county. His death followed an illness of many months. Doctor Haskell is survived by his wife and one daughter. He was a member of the Richland County, Wisconsin State, and American Medical Associations.

Dr. J. H. Pflueger passed quietly away at his home in Holmen, Tuesday, March 25, at the age of 65. Doctor Pflueger was born in Lithopolis, Ohio, August 21, 1853, and graduated from the Starling Medical College, Columbus, Ohio, in 1879. From Ohio he came directly to Holmen where he practiced his profession for four years, then removing to Grant County where he practiced for seventeen years. In 1908 he returned to Holmen where he practiced until the time of his death. Doctor Pflueger was an honorary member of the La Crosse County Medical Society.

While those in attendance were momentarily expecting the death of Dr. J. A. Marchessault of Ashland, suffering from blood poisoning, his wife, worn out through watching and anxiety, died. Doctor Marchessault died a few moments later. He was a member of the Ashland County, Wisconsin State, and American Medical Associations.

Miss Jane A. Delano, who died April 15, at Base Hospital 8 at Sauvigny, France, was one of the foremost figures of the nursing world. It was under her direction that more than 30,000 nurses were recruited through the American Red Cross for service with the army and navy after the United States entered the great conflict. She was born in Watkins, New York, in 1862, and graduated from the Bellevue Hospital, New York, in 1886, and two years later rendered her first patriotic service to her country by volunteering to nurse yellow fever victims in Jacksonville, Florida. Miss Delano served three times as president of the American Nurses' Association and also served several years as head of the directorate of the American Journal of Nursing.

Surgical Treatment. A Practical Treatise on the Therapy of Surgical Diseases for the Use of Practitioners and Students of Surgery. By James Peter Warbasse, M. D., formerly Attending Surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo volumes, and separate Desk Index Volume. Volume III contains 861 pages with 864 illustrations. W. B. Saunders Company, Philadelphia and London. 1919. Per set (Three Volumes and the Index Volume), Cloth $30.00 per set.

The third and last volume of this series of surgical treatment carries out to the end the systematic effort and simplicity evidenced in the other two volumes. The third volume covers such subjects as hernia, abdominal surgery, genito-urinary surgery, gynecological surgery, the surgery of the extremities, first aid, etc.

The illustrations, many of which are diagramatic, are plentiful and will be found helpful to the student. A section on plastic and cosmetic surgery deserves especial mention.

The index volume which accompanies the third number of this set covers everything in the three volumes and comprises a list of subjects totaling 123 pages. We predict for Warbasse's "Surgical Treatment" a most successful sale and a place in our surgical literature which is already guaranteed for many years to come.

Estimates prepared by the United States Public Health Service indicate in the South the ravages of typhoid fever, tuberculosis, hookworm, and pellagra, all together are not as serious as those caused by malaria.

Still relying on the Patent Medicine Almanac? Better discard it and get the new one issued by the United States Public Health Service, Washington, D. C. Sent free on request.

MISCELLANY.

There once was a diagnostician,
In love with a pretty technician.
Said he, at a dance "Won't you give me a chance?"
Said she, "I prefer the clinician."

PUBLIC HEALTH AND LABORATORIES

Edited By W. D. STOVALL, Madison and
MRS. LOUISE BRAND, Milwaukee

ADVANCEMENT OF PUBLIC HEALTH.

A series of three articles dealing with public health methods, organizations, private health agencies.

BY W. D. STOVALL, M. D.

As one views the efforts of health work everywhere, questions concerning methods and the probability of their ultimate success naturally arise. There are two chief activities of health departments. One is the application of known scientific facts concerning the spread of disease for their prevention, and the other is the education of people to the realization of the need of public health organization.

The educational work is the foundation work for a good health organization because the accomplishments of any health department depends largely upon the support which it has from the people. If for the enforcement of public health laws we must depend upon a large and active police force, the best can not be realized. Health departments must have police power and at times exercise it upon the few who refuse to co-operate for the good of all but when such force is required the support of the majority of the citizens should be behind the department. This support cannot be expected until people have been educated to realize the need of effective health organizations and to appreciate the service which can be rendered through them.

Health Boards have been engaging in this educational work and are realizing its importance more and more. The question which I wish to ask is: Have the methods which have been and still are employed been as successful as can be expected, and have they brought in an adequate return for the money invested? The methods usually employed are the distribution of pamphlets containing information on a variety of subjects, and sending out the so-called Public Health Lecturer. Through these two agencies something of course is accomplished. There are some fundamental reasons however why the necessary educational work can not be entirely or even to a large extent done through these two mediums.

Let us consider first the distribution of pamphlets, bulletins, and reports. In the first place the cost of this literature is large. Does it get results? It seems to me that from the nature of the thing it cannot accomplish much. The mail is flooded with second class matter. Everybody whose address can be obtained receive daily mail which is thrown into the waste basket before it is opened. Literature on public health matters usually comes as all the other pamphlets do, and it seems to me is very apt to receive about the same attention. And that is not all of the difficulty; in fact, the most important objection is yet to come. The pamphlet does not and cannot touch vitally the lives of the individuals who read them. If we grant that a large proportion are read, we must concede that a large per cent of those who receive such literature are by the nature of the circumstance which brings it to them least in need of the information. And still further than that, the reader seldom receives the pamphlets when he is most in need of information concerning disease and its prevention, and not being in need he seldom sees the importance of considering the enemy of which it treats and which to him is often an imaginary one.

As for the public health speakers; they frequently know little more than the audience of how disease is spread, and the problems which are involved in their prevention. The speaker may be and usually is qualified in his field but almost anybody who is in any sort of welfare work feels perfectly qualified to talk on disease prevention. The chief reason, however, for their failure is that they come in such casual and accidental relation with the people and life of the community. They usually arrive on a late train, speak once, and are gone. The talk must cover a great many subjects and therefore is very general. This does not help the community to solve any of its sickness problems. Because of these vital defects a great amount of good cannot be realized by public speakers.

If, then, these methods seem inadequate for educating the public to the need of preventive measures, and to the use of simple precautions for the prevention of disease, what seems to be better? The answer to that question is much simpler than its accomplishment. Education of the sort needed

in public health can best be accomplished by demonstration, and through people who offer something more than a little advice; who offer some assistance at a time when it is badly needed. Because the physician occupies this advantageous position in the community, he can be the greatest educator in the public health field, and next to him is the public health nurse. Because of her primary interest in public health, the nurse actually is exercising the greatest amount of influence for public health. It seems to me though that the responsibility of the physician in this matter is especially acute. He sees his patients at a time when they are in distress, at a time when they are grasping for any opportunity which will prolong their own lives and protect those of their families. This offers the golden opportunity to engage the minds of the family on disease prevention. A few words spoken at this time by the physician has more effect, has more real educational value than any bulletins or public speakers could effect in a life time. The time consumed in giving this much needed instruction concerning the disease with which the patient is suffering, a few remarks as to how it is spread from one individual to another, from one member of the family to the other, and what means may be employed to prevent it would be inconsequential as compared to the good which would be accomplished.

It is the duty of every physician to take enough time in every case to explain to the family the infectious nature of disease, if it is infectious. In most cases the patient should be given this information. There are very few instances where anything is gained by keeping from the patient the nature of the disease from which he or she is suffering. In almost every case where a policy of secrecy is followed, widespread harm is the result. There can be no excuse either for a physician turning from his office with a box of pills and a casual and careless remark one who has appeared with a complaint or at least an imaginary one. Frequently incipient infections can be detected and frequently when a patient is carelessly turned away with the consolation that his all-wise doctor has cast a knowing glance upon him and pronounced him all right he returns to that doctor in a few weeks or a few months with an advanced infection.

When one considers the opportunity afforded, the great responsibility of the physician is realized. By him people are reached intimately and rapidly. His influence is by no means confined to the family. If his duty is properly performed, the whole community, county, state, and nation soon see and feel its effect. The spread of information by him is almost like throwing a rock in a pool of water and watching the waves grow wider and wider. In one family the disease would be pneumonia, in another tonsillitis, in another tuberculosis, etc. Each physician would be giving instructions to a number of people on a number of different diseases. As the community visited back and forth each one would tell their experience in their recent illness, and would discuss the directions given for its prevention. It would not be long until the information would be spreading from two sources. I cannot conceive of any better method of educating the public on health matters.

Such a plan would work out to the benefit of both the public and the medical profession. The people would learn to seek advice early and oftener. Instead of the doctor having to make long and wearing trips to see patients who are desperately sick, and for whom he too often realizes his inability to do anything, his practice would become more and more office work. This is desirable both for the physician and the public.

Next to the physician the most important person in health work and the one who holds out more hope than any other in the sort of educational work needed is the public health nurse. With the proper training and personality she can go into any community and soon win the affection and support of every citizen. She gets close to the people in their daily lives, helps to solve difficult problems, and brings relief to some when no other aid is in sight. She gets close to the people, and is able to promote the advance of public health just in proportion as she gives herself to the community and is able to give active assistance to those who need help. Being in such close and intimate relation with the life of the community her opportunity for educating the people to the support of health organizations cannot be over estimated. Around her the sentiment for well organized health departments will be crystallized. She is the foundation upon which community health organizations will be built. Instead of starting at the top, the full time health officer, and trying to build the substructure next, and without the co-operation of the community because the community has not realized the need of a health organization,

the public health nurse represents the base, the foundation of the structure which will be demanded by the community after a few years of education. The public health nurse will bring the communities to a realization of the importance and the need of health organizations. This means of course that every community will have a full time health officer and all the rest of the organization which is necessary to make a health department function effectively.

The physicians co-operating with public health nurses and health departments can hasten the day when health departments will not be looked upon as a big police force which is ever present to restrict the privileges of people but as the most important governmental agency for the protection of the public.

TUBERCULOSIS LEADS IN THE DISABILITIES OF MEN RETRAINING.

(Extract from The Vocational Summary, March, 1919.)

Tuberculosis has taken the largest toll of all disabilities which the men have who are taking retraining courses under the direction of the Federal Board suffered from. Amputation has occurred in only 2 per cent of the 7,710 cases which had been dealt with up to January 31, 1919. The War Risk Insurance Bureau gives out the statement that approximately 3,000 men of the A. E. F. have lost arms or legs, about 110 have been blinded, and 5,195 have been adjudged to be suffering with tuberculosis.

The following table is a distribution of the disability cases dealt with by the Board up to January 31, 1919.

DISABILITIES	Total	Per Cent
Eyesight	190	2.5
Wounds and injuries to legs necessitating amputation	82	1.0
Wounds and injuries to arms necessitating amputation	84	1.0
Wounds and injuries to legs not necessitating amputation	246	3.5
Wounds and injuries to arms not necessitating amputation	73	.9
Wounds and injuries to hands not necessitating amputation	47	.6
Wounds and injuries to head	38	.5
Hernia	74	.9
Miscellaneous wounds and injuries	155	2.0
Chest complaints and tuberculosis of lungs	2,791	36.2
Tuberculosis of the bone	148	1.9
Rheumatism	258	3.4
Heart Disease	843	10.9
Epilepsy	75	.9
Nervous diseases, shell shock, etc	294	3.9
Insanity	318	4.0
Deafness	112	1.4
Miscellaneous diseases	1,174	15.4
Not stated	708	9.1
Total	7,710	100.0

WISCONSIN REPRESENTED.

Prof. John R. Commons of the University of Wisconsin, Dr. Victor C. Vaughan of the United States Public Health Service, and Dr. Livingston Farrand, chairman of the Central Committee of the American Red Cross, will be the principal speakers at the meeting of the Advisory Council of the National Tuberculosis association, to be held in conjunction with the annual meeting of the association at Atlantic City, N. J., Monday evening, June 16. The general subject for discussion, as tentatively stated, will be "The Place of the Anti-Tuberculosis Campaign in the General Public Health Movement."

PRAISE FOR WISCONSIN.

Wisconsin's campaign to secure better and more adequate care for its feeble-minded is attracting national interest and commendatory comment. Extracts from the bulletin issued by the Wisconsin Conference of Social Work, appearing in the last issue of the Wisconsin Medical Journal, have been quoted widely. The bulletin receives extended notice in a recent issue of The Survey, with the suggestion that it be adapted to the needs of other states. The Survey says:

"Better care for the feeble-minded is a live issue—a burning, paramount issue, if we judge by importance rather than by the prospect of any early satisfactory outcome — in every American state and in every naton of both hemispheres. It

is more important than political boundaries or forms of government. It is more important than Illiteracy or Americanization.

Some very good publicity on this subject has just appeared in Wisconsin, the purpose of which is to get through the legislative bills which will enable the Board of Control to give more adequate care. This excellent propaganda comes from the State Conference of Social Work. Judge E. Ray Stevens is chairman of the Social Legislative committee. With changes of figures and names of institutions, the Wisconsin circular — copies of which may be secured from W. F. Hintzman, secretary of the conference in Madison—would almost equally fit other states, except that in some not even a start has been made in providing institutional care for the feeble-minded and epileptic."

HEALTH PROMOTION WEEK IN ILLINOIS.

By official act of the Illinois State Legislature, the week beginning May 11 is to be observed as Health Promotion Week, and the second week in May, 1920, is also set aside for the same purpose. The State Department of Health is designated as the agency to have charge of the program and the health activities and the people of the state are urged to emphasize in every possible way the need for united action against all communicable diseases and the causes thereof. The joint resolution of the state senate and house of representatives calls attention to the following facts:

That 24,000 men, women, and children in the state of Illinois died of communicable diseases during the past fiscal year.

That more than 83,000 cases of communicable diseases were reported during the year to the State Department of Health.

That it is conservatively estimated that in Illinois the annual cost of diseases which are communicable and therefore preventable is upwards of $155,000,000.

The State Department of Health has designated Walter D. Thurber, executive secretary of the Illinois Tuberculosis association with whom the plan for Health Promotion Week originated, as director general of the campaign. His services are loaned by the Illinois association. Various state departments and a large group of extra-governmental health and social agencies are co-operating with the State Department of Health.

The week will be ushered in with Health Promotion Sunday and services in the churches. Monday will be Clean-up day, Tuesday "Swat the Fly" day, Wednesday "Better Babies" day, Thursday Medical Examination day, Friday "America's Future Citizens" day and Saturday "Pageant" day.

OF INTEREST TO CRUTCH USERS.

An improved crutch of unusual merit recently patented, will bring much comfort and satisfaction to the increasing army of crutch users. It is a well known fact that the general design and finish of crutches has remained dormant for the past fifty years. The majority of those on sale, and seen daily on the streets, have received no more thought or attention as to construction and requirements, than such articles as step-ladders and ironing-boards. Crutches with crudely and imperfectly formed arm rests, wrongly located hand piece and too rigid construction, are a constant discomfort to the unfortunate user. The improved crutch referred to, has a specially designed arm piece devoid of angles, the entire surface being rounded and finished in special enamel or celluloid, which prevents friction and wear of clothing, also chafing of the body. In the underside are circular bored openings containing invisible compression springs suited to the weight of the user; these openings also receive the ends of the crutch staffs which are slidable against the springs, the combination acting as a cushion or shock absorber. The arm piece being entirely independent of the crutch uprights, adjusts itself to the various positions necessary in sustaining the body. If the crutch is placed forward, the front spring receives the principal weight and is compressed, as the body is carried forward, the weight being transferred to the rear springs, a rocking or cushion effect is the result. The curved surface of the arm piece does not change its form through pressure of the body which would be the case, if it were padded or upholstered, a condition found most objectionable on account of its constant change of surface, which causes heating and chafing. A metal strap attached to the arm-piece connects with the staffs, retaining the parts in movable relation. The crutch proper is made from selected close grained woods, and highly finished. The construction being light and strong, permits the crutch to yield and adapt itself to the various positions of the swaying body when walking. The proper distance from arm to hand piece, also correct length of crutch is readily secured by reducing the ferrule and upper ends of the staffs to meet the required measure. Exhaustive tests have proved the great comfort, merit and durability of this timely improvement.

If you will make a ring of a branch of fresh cut myrtle, and put it upon your ring finger: it cures an aposthume of the axilla.—*Alb. Magnus.*

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BOOK REVIEWS

ROENTGENOTHERAPY. By Albert Franklin Tyler, B. Sc., M. D., Professor of Clinical Roentgenology, John A. Creighton Medical College; C. V. Mosby Company, Publishers. St. Louis, 1918. Price, $2.50.

The outline of this book, as stated in the preface, is excellent, and there is a very definite need for a book corresponding to this outline. It is unfortunate that the book itself does not measure up to the author's intentions.

The volume is supposed to be for beginners in Roentgenotherapy, but it presumes a far greater knowledge of roentgenology than would be possessed by a beginner.

Throughout the book, all directions and specifications are given in a sketchy manner, which makes the book read easily, but is not the exact scientific information which a work of this sort should contain. The case histories are given entirely too briefly, and few of them are of any value because the exact method of arriving at a diagnosis in malignant conditions is not stated. The term Pathology is used in a very loose and colloquial manner.

In two instances, the book is very misleading, and in one, the directions, if followed, might give rise to serious consequences. In a discussion of the treatment of uterine fibroids, the author satisfies himself and proceeds with X-ray therapy, if Carcinoma has been ruled out in the case. He does not mention that it has been well demonstrated that in 3 to 5% of all fibroid conditions of the uterus, sarcoma is present. It may be proper to treat some cases of uterine fibroids with the X-ray, although this is not accepted by most gynecologists, but the person who does this and also some responsible member of the patient's family should know that there is a 3 to 5% chance that a sarcoma of the uterus is so treated and is thereby denied operative treatment.

The author speaks of leukoplakia as being one of the most resistant forms of malignancy. It is important not to confuse leukoplakia and epithelioma, for leukoplakia is certainly not a malignant disease. It is important, of course, to recognize that epithelioma is frequently found along with leukoplakia and may be secondary to irritation from the former. This, however, is a theory and not a fact. If the roentgenotherapist finds that the epithelioma associated with leukoplakia is a resistant form of malignancy, this would be an excellent reason why these cases should be given early operative treatment followed by roentgenotherapy, rather than roentgenotherapy alone.

The book seems a bit misleading in its optimism concerning roentgenotherapy. The volume is interesting, but cannot be recommended for a place on the general practitioners' book shelves. W. T.

A TEXT-BOOK OF OBSTETRICS, Eighth Edition. By Barton Cooke Hirst, A. B., M. D., L. L. D., F. A. C. S., Professor of Obstetrics, University of Pennsylvania. Gynecologist to the Howard, Orthopaedic, and Philadelphia General Hospitals. Octavo, 660 pages. Cloth, $5.00 net. Published 1918 by W. B. Saunders Company, Philadelphia.

In the eighth edition of this excellent work the text has been considerably condensed, with a view to eliminating matter not of especial value to the medical student or the general practitioner. Additions have been made which include the more important advances made in obstetrics since the 1912 edition.

A detail which is exceptionally well dealt with is "Examination of Women". Lucid instructions and photographic illustrations make the author's ideas exceedingly clear and offer to the student knowledge which is so essential to skillful diagnosis.

The chapter on extra-uterine pregnancy is a thorough discussion of the subject and is well illustrated.

Much space is devoted to the discussion of operative technique. Emphasis is put upon the importance, in clinics, of all sterilizing, scrubbing, preparation of patients and other work requiring aseptic technique being done in full view of the students. While operations or deliveries in the home are not advocated the author realizes that for the country practitioner such is inevitable, and he accordingly furnishes many clever suggestions as to the use of articles at hand.

There is little given beyond the usual text-book description, in regard to Caesarean section. The indications for the operation are hazily stated. The writer considers that the author has made a serious mistake in that he has given no warning as to the undesirability of Caesarean sections unless definitely indicated. A text which professes to teach "undergraduate students and practicing physicians" all that they should know with regard to obstetrics should take some stand against the mania which prevails among certain younger men, for performing Caesarean sections for even the slightest abnormalities.

The greater portion of the text is above the average for books on this subject and the illustrations far surpass those of less recent publications.

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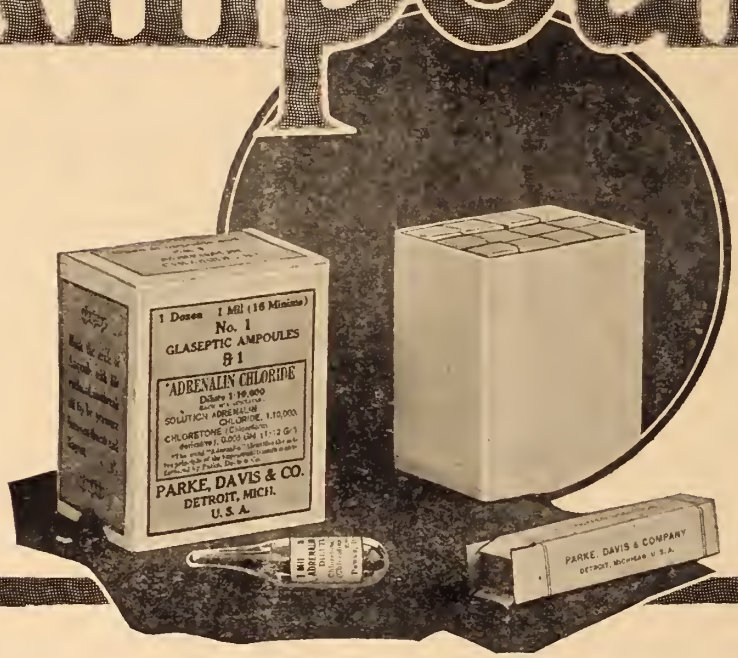

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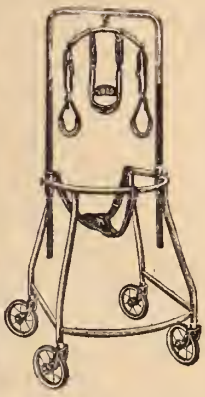

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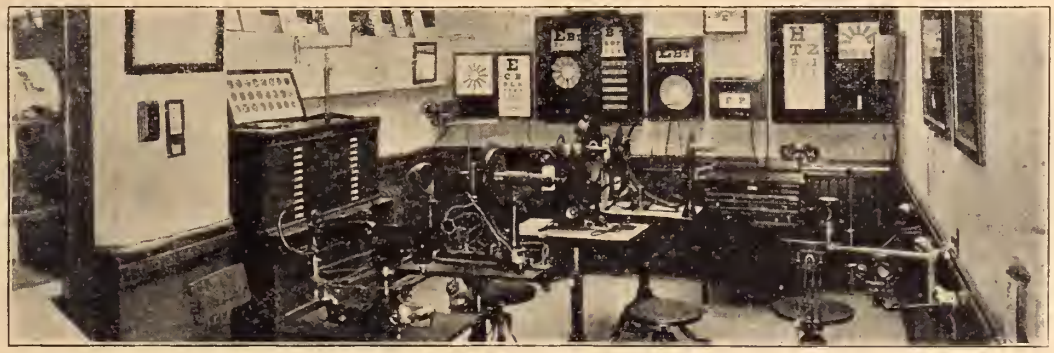

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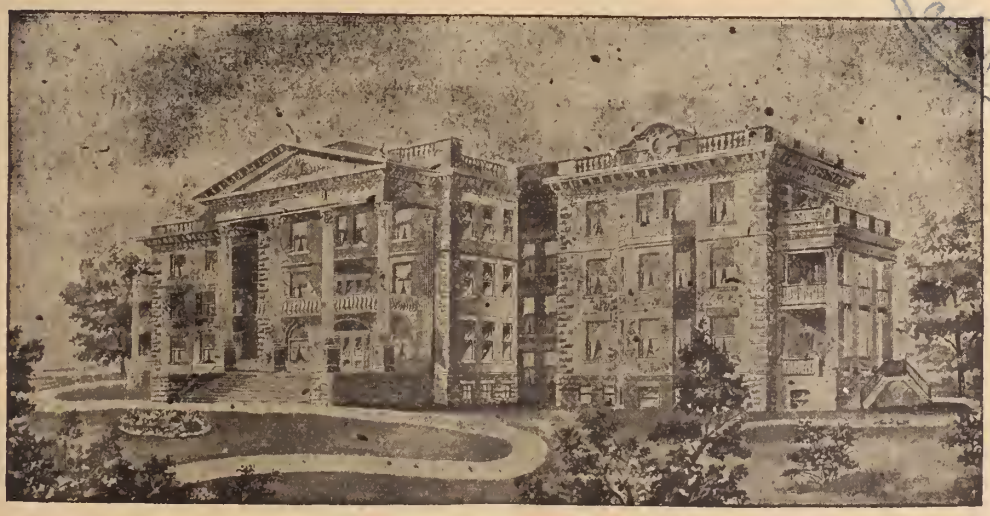

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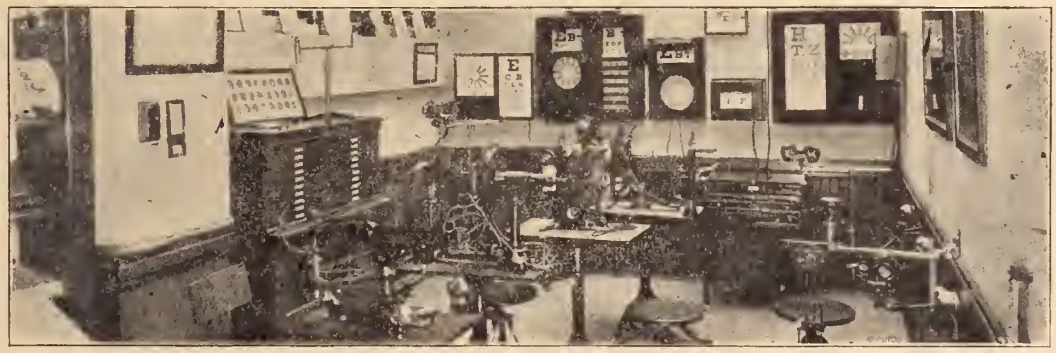

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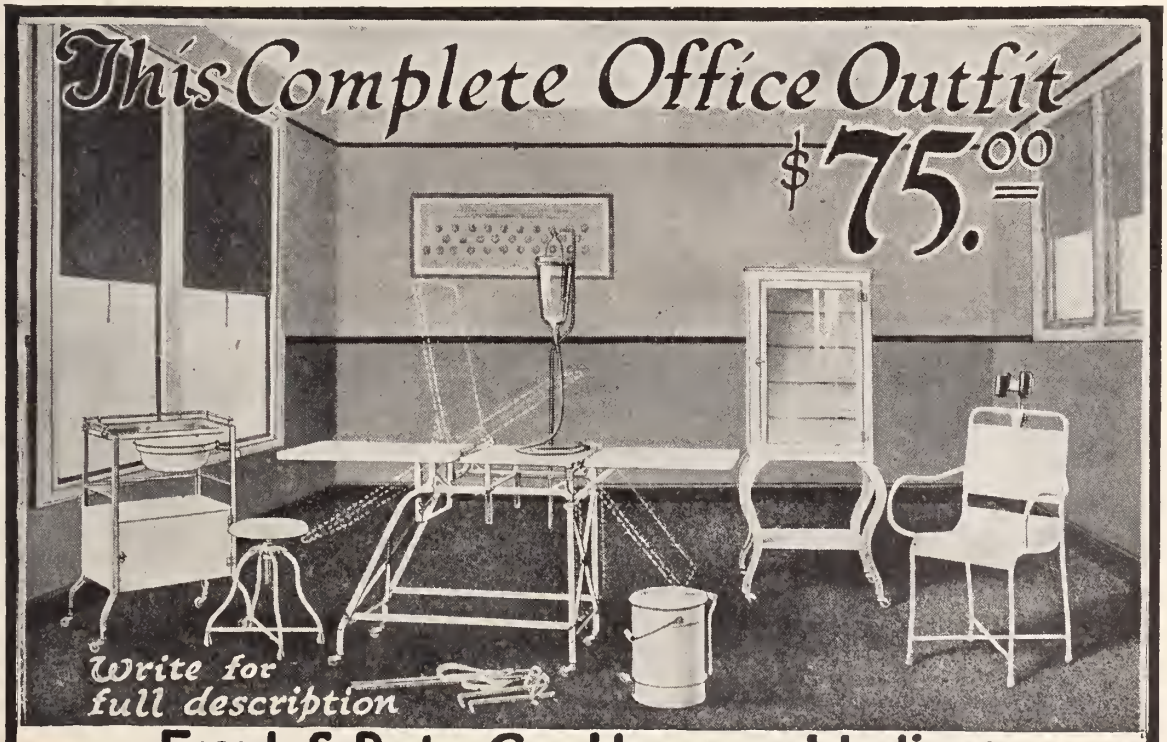

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THERAPEUTIC NOTES

SOME FACTS ABOUT YEAST.

The subject of yeast is of importance because, first, as has been pointed out in an editorial article in the Journal of the American Medical Association (Jr. Am. M. Asso., 1916, lxiv, 1390) it possesses a distinct nutritive value, and because, secondly, it possesses therapeutic qualities. It is abont some of the forms of yeast and their therapeutic properties that we wish to write. The matter of ycast treatment has recently received impetus as the result of the publication in the Jr. Am. M. Asso. (Oct. 13, 1917) of an article by Dr. Philip B. Hawk and collaborators, which represents work done in the Laboratory of Physiological Chemistry of the Jefferson Medical College, and the Philadelphia General Hospital, both of Philadelphia, and the Roosevelt Hospital, New York.

Hawk and his colleagues obtained strikingly good results from the use of yeast in many pathological conditions, especially the purulent skin conditions such as acne and furunculosis and in constipation. That they did so is not at all surprising, for yeast has always acted well in these skiu conditions, as is well known. Hawk meutions that yeast has been used in medicine since the days of Hippocrates (who used it in the treatment of leucorrhea); not, however, until the middle of the ninetcenth century, was its use looked on favorably by the medical profession. Since then, its value has been attested by numerous observers, who have employed it in a variety of pathological conditions. Its value in certain skin conditions has been freely acknowledged by dermatologists—for instance, Schamberg has secn good results from its use in the treatment of ordinary furunculosis (Diseases of the Skin and the Eruptive Fevers, 1915) although it failed him in the furunculosis accompanying smallpox.

Hawk's researches are novel in that he employed as a therapeutic agent not the time-honored brewers' yeast, but the familiar Fleischmann's yeast of the bakeries aud the household. This is the first time, it seems, that bakers' yeast has been employed systematically as a therapeutic agent, although Louvel (Rennes med., 1905-6—fasc. 10, 16-19) seems to have used it in the treatment of sundry infectious diseases, and according to Cailliau (These de Paris, 1908) it was used in 1896 by De Backer, who mixed it with equal parts by weight of white honey, and who, having used it thus in the treatment of furunculosis, considered that it was more active and better supported than ordinary yeast.

That brewers' yeast should have been used in the past is not at all surprising when we call to mind that, in all probability, in modern times at least, it was extensively used and tested by the employees of breweries, who found it readily accessihle. A special virtue seems to have attached to brewers' yeast, probably from this reason. For instance, the yeast specified by Schamberg (loc. cit) is fresh brewers' yeast, and the U. S. Pharmacopaeia of 1876 defines yeast (fermentum) as "a peculiar insoluble product of the fermentation of malt liquors." It was dropped from the Pharmacopaeia of 1880, and has since remained unofficial. The U. S. Dispensatory (Remington and Wood) of 1918, describes it as a "flocculent, frothy, somewhat viscld semlfluid of a dirty yellowish color, a sour vinous odor and a bitter taste." Suffice it to say, the appearance of brewers' yeast is not at all familiar to very many physicians, one reason being that it is not immediately available, except in some large cities. In country districts that are remote from breweries, the use of brewers' yeast is attended with serious difficulties.

Compressed yeast, the undried product, is readily obtained and there is no reason why it should not be largely used.

The National Formulary, 1916, under the term "Cerevisiae Fermentum Compressum" recognizes compressed yeast and describes it as follows: "The moist, llving cells of Saccharomyces cerevisiae Meyen (Fam. Sacchyromycetaceae) or of other species of Saccharomyces, combined with a starchy or absorbent base. White or yellowish-white, soft, and easily broken masses, having a characteristic slightly sour odor, and not more than a faintly acid reaction to litmus. When examined under the microscope, numerous oidium and mycoderma cells and starch grains are visible. Compressed yeast must not be used unless fresh, and free from mildew and musty odors." Sadtler (Industrial Organic Chemistry, 1900) has also given a good description of compressed yeast: "It should be ouly slightly moist, uot sloppy to the touch; the color should be a creamy white, when broken it should show a fine fracture; when placed upon the tongue it should melt readily in the mouth. It should have an odor of apples, not like that of cheese; neither should it have an acid taste or odor. . . . ."

A certain disadvantage of fresh brewers' yeast in therapeutics has been mentioned, i. e., its non-availability. Certain other objections to its use readily come to mind, among them being the fact that as a rule it is decidedly non-uniform both as to composition and as to action. We would readily suspect this when we recollect that in the yeast of the breweries two well-marked varieties of saccharomyces have been recognized; a top yeast most active at 16°-20° C. and a bottom yeast most active at 6°-8° C. On the different behavior of these varieties, different methods of brewing have been founded. Lardier (Thèse de Paris, 1901-1902) calls attention to the fact that brewers' yeast obtained from different breweries behave differently so far as therapeutic action is concerned; moreover, that the therapeutic action of yeasts obtained from different barrels in the same brewery varies. Also the yeast in the same barrel varies at different stages of fermentation. He states that the difference explains in part the varying therapeutic results of different observers.

Besides varying in proportions of the different species of saccharomyces they contaln, brewers' yeasts are apt to be admixed with various wild yeasts that enter the llquid from the air.

There is a difference of opinion concerning the nature of the constituent of the yeast which gives it therapeutic value. Some investigators claim a direct bactericidal effect, others regard such effect as due to by-products of fermentation such as alcohol and various acids, still others regard the action as due to the chemotactic influence of the high nucleln content of the yeast. According to the Dispensatory, the experiments of Walzou and Sacharow have shown that yeast increased the opsonic index of dogs for staphylococcl and streptococci. This may help to explain its favorable action in infectious conditions.

The Dispensatory mentions the fact that the ordinary yeast cake of American bakers may well he substituted for brewers' yeast. In view of Hawk's investigations this statement may very well be true. Compressed yeast is generally to be preferred because of the fact that it is carefully standardized and a uniform product is always obtainable. Sadtler refers to the researches of Hansen—who early separated various species of yeasts used in the industries. Among these varicties of Saccharomyces, cerevisial and Saccharomyces Pastorinus were used in the brewing of beer; saccharomyces ellipsoides in the manufacture of wine. Sadtler states that it is prepared as compressed yeast in cakes, generally with the addition of potato-starch. The National Formulary does permit the presence of species of saccharomycetaceae other than Sacchyomyces cerevisiae Meyen. At all events, the composition of bakers' ycast can be controlled, and this yeast possesses the advantage of availability and uniformity.

Next Meeting of the State Society at Milwaukee, Oct. 2-4

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